

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
|--|--|-------------------|---|---|------|---|---------------------------------------|---------------------------------|---|----------------------------------|----------|---|------|
| Items 8,9 FilmG2H1 2-27-61 et  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| 1795 CERTIFICATE OF DEATH  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| Reg. Dist. No. 01774   |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| 1. PLACE OF DEATH<br>a. COUNTY   |  |                   | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                          |   |      | c. LENGTH OF STAY IN lb   |                                       |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |                                  |          |   |      |
| Cecil MARYLAND   |  |                   | Perry Point,  |   |      | 36 days   |                                       |                                 | Virginia  |                                  |          |   |      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |                   | Veterans Hospital   |   |      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |                                 |   |                                  |          |   |      |
| 3. NAME OF DECEASED<br>(Type or print)   |  |                   | First   | Middle  | Last | 4. DATE OF DEATH  | Month                                 | Day                             | Year  |                                  |          |   |      |
| John W ALEXANDER   |  |                   |   |   |      | February  | 12,                                   |                                 | 19 61   |                                  |          |   |      |
| 5. SEX   |  | 6. COLOR OR RACE  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |      | 8. DATE OF BIRTH  |                                       | 9. AGE (In years last birthday) |   | IF UNDER 1 YEAR IF UNDER 24 HRS. |          |   |      |
| Male   |  | White             |   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |      | 1/2/86 1895   |                                       | 6566 yrs.                       |   | Months                           | Days     | Hours   | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |                   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |      | 11. BIRTHPLACE (State or foreign country)   |                                       |                                 | 12. CITIZEN OF WHAT COUNTRY?  |                                  |          |   |      |
| Sign Painter   |  |                   |   |   |      | Ryan, Virginia  |                                       |                                 | U.S.A.  |                                  |          |   |      |
| 13. FATHER'S NAME  |  |                   |   |   |      | 14. MOTHER'S MAIDEN NAME  |                                       |                                 |   |                                  |          |   |      |
| JAMES V. ALEXANDER   |  |                   |   |   |      | ALLIE GRIFFITH  |                                       |                                 |   |                                  |          |   |      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)   |  |                   | 16. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT   |                                       |                                 | Address   |                                  |          |   |      |
| Yes WW I   |  |                   | Unknown   |   |      | Hospital Records, VAH., Perry Point, Md.  |                                       |                                 |   |                                  |          |   |      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gangrene of small intestine INTERVAL BETWEEN ONSET AND DEATH 5 days  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| 420-1<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Emboli from mural thrombosis of heart. 5 days   |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| DUE TO (c) Myocardial Infarction. 5 weeks  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)                                   |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                 |  |                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |      |   |                                       |                                 |   |                                  |          | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.   |  |                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   |      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |                                       |                                 | 20f. (City or town)   |                                  | (County) | (State)   |      |
| VA   |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| 21. I certify that I attended the deceased from Jan 6, 19 61, to Feb 12, 19 61, and that death occurred at 9:15 A.M. from the causes and on the date stated above. |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| ADDRESS (Street, city or town, state)  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| DATE SIGNED  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| ACTUAL SIGNATURE <u>Albert L. Mooney</u> M.D. VAH., Perry Point, Md.   |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| PHYSICIAN'S NAME (Type) Dr Albert L. Mooney, Pathologist.  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF |   | 22c. NAME OF CEMETERY OR CREMATORIAL  |      |   | 22d. LOCATION (City, town, or county) |                                 |   | (State)                          |          |   |      |
| Burial   |  | 2-15-61           |   | Arlington National  |      |   | Ft. Myers, Va.                        |                                 |   |                                  |          |   |      |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 520 Mt Vernon Blvd., Alexandria, Va.  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| WM. DEMAIN & SON,  |  |                   |   |   |      |   |                                       |                                 |   |                                  |          |   |      |
| 24a. REC'D BY REGISTRAR  |  |                   | 24b. REGISTRAR'S SIGNATURE  |   |      |   |                                       |                                 |   |                                  |          |   |      |
| DATE FEB 15 '61  |  |                   | Colvin S. Keay  |   |      |   |                                       |                                 |   |                                  |          |   |      |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1796

## CERTIFICATE OF DEATH

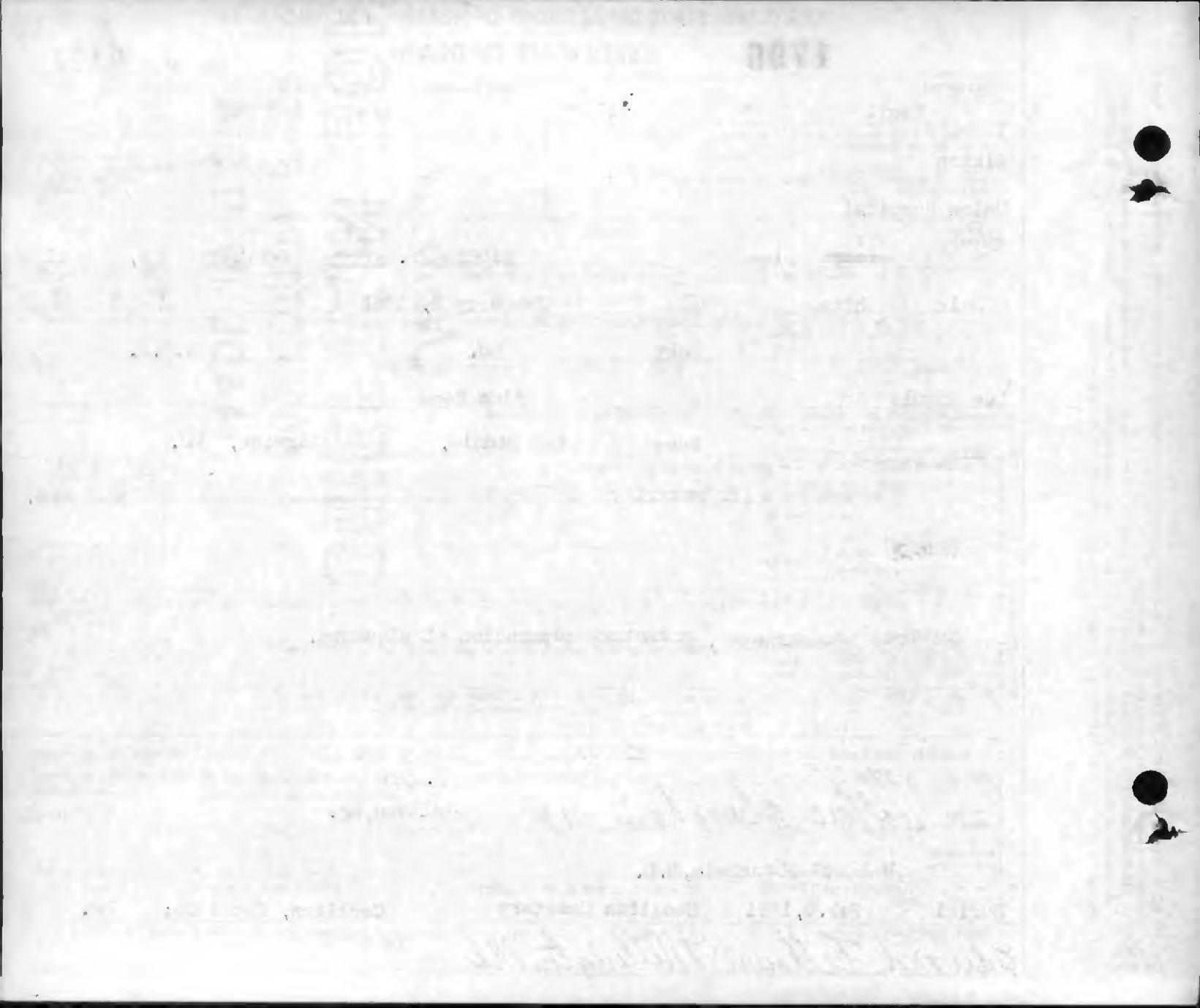
Reg. Dist. No. 01775

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

|  |                                  |   |  |  |   |  |                  |                              |   |  |                                |
|--|----------------------------------|---|--|--|---|--|------------------|------------------------------|---|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>   |                                  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>               |  | c. LENGTH OF STAY IN 1b<br>RURAL   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |                  | b. COUNTY<br><b>Maryland</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Warwick</b> |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Union Hospital</b>  |                                  | e. STREET ADDRESS<br>--   |  | d. STREET ADDRESS<br>--  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |                  |                              |   |  |                                |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Baby Lee</b>  |                                  | First   | Middle   | Last   | 4. DATE OF DEATH<br><b>Biddle Jr.</b>               | Month  | Day              | Year                         |   |  |                                |
| S. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                      | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>February 2, 1961</b>  | 9. AGE (In years last birthday)<br>yrs.<br><b>1</b> | IF UNDER 1 YEAR<br>Months<br><b>1</b>  | Days<br><b>2</b> | Hours<br><b>52</b>           | Min.<br><b>52</b>   |  |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baby</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                  |                              |   |  |                                |
| 13. FATHER'S NAME<br><b>Lee Biddle</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Alma Reed</b>   |   |  |                  |                              |   |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>[If yes, give war or dates of service]   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | INFORMANT<br><b>Lee Biddle,</b>  |   | Address<br><b>Warwick, Md.</b>   |                  |                              |   |  |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br>760.5<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO _____<br>(c) _____<br>DUE TO _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Cerebral hemorrhage premature separation of placenta.</b> |                                  |   |  |  |   |  |                  |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours.</b>  |  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>3 Feb 61</b> |  |  |   |  |                  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m.<br>p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> At work <input type="checkbox"/>                 |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Cecilton, Md.</b> |   | 20f. (City or town)<br>(County)<br><b>Cecilton, Md.</b>  |                  | (State)                      |   |  |                                |
| 21. I certify that I attended the deceased from <b>3 Feb 61</b> , 19 <b>61</b> to <b>3 Feb 61</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>3 Feb 61</b> , 19 <b>61</b> , and that death occurred at <b>3.15 PM</b> from the causes and on the date stated above.  |                                  |   |  |  |   |  |                  |                              |   | ADDRESS (Street, city or town, state)<br><b>Cecilton, Md.</b>  | DATE SIGNED<br><b>6 Feb 61</b> |
| ACTUAL SIGNATURE<br><b>Wallace Obenshain M.D.</b>  |                                  |   |  |  |   |  |                  |                              |   |  |                                |
| PHYSICIAN'S NAME (Type)<br><b>Wallace Obenshain, M.D.</b>  |                                  |   |  |  |   |  |                  |                              |   |  |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Feb. 6, 1961</b>  |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Cecilton Cemetery</b>                               |   | 22d. LOCATION (City, town, or county)<br><b>Cecilton, Cecil Co.</b>  |                  | (State)<br><b>Md.</b>        |   |  |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Edward Fellows, Wellington, Md.</b>   |                                  | ADDRESS<br><b>2065161282</b>  |  | 24a. REGD. BY REGISTRAR<br><b>1968 61</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Edward J. Fellows</b>   |                  | DATE                         |   |  |                                |



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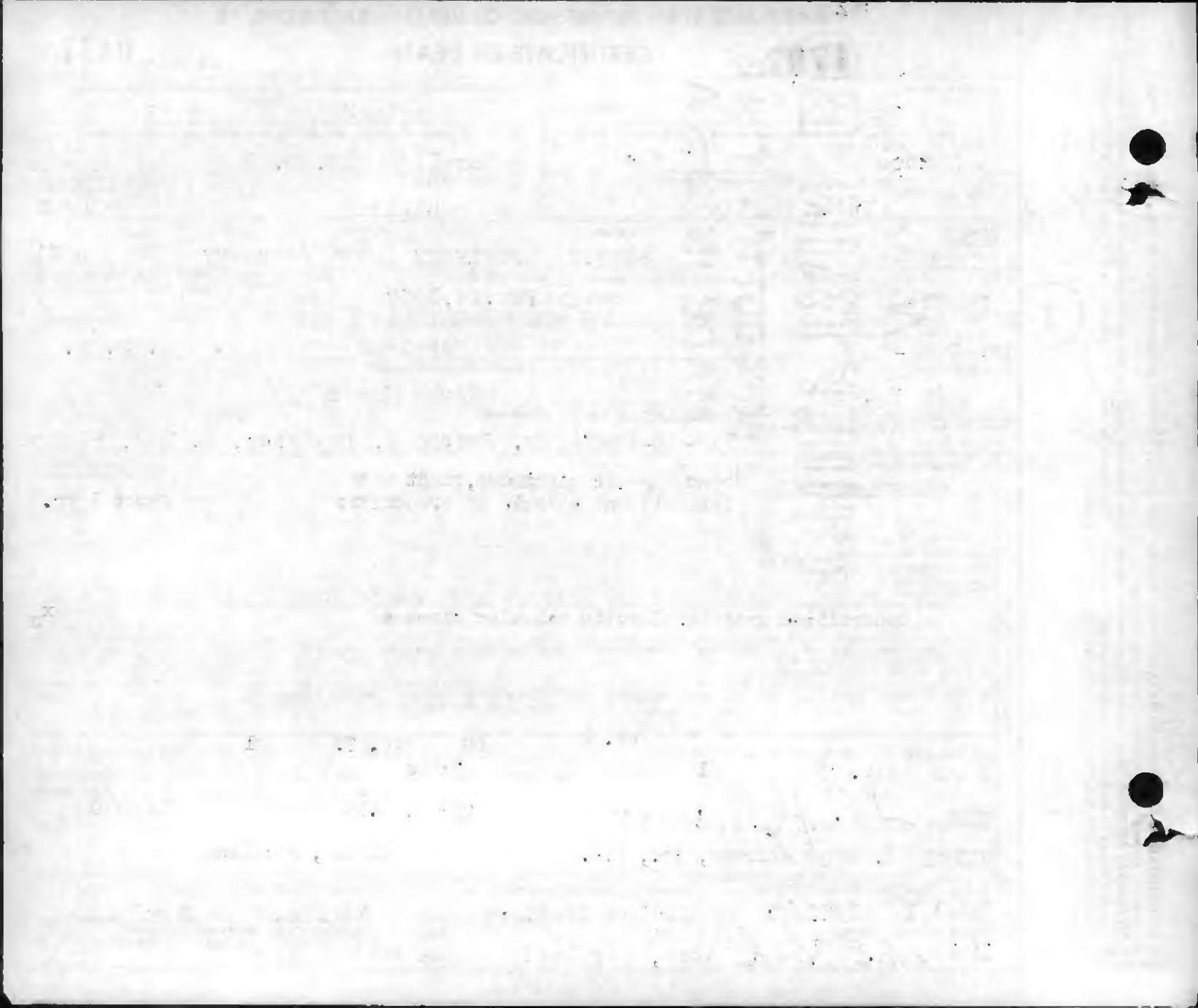
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1797

## CERTIFICATE OF DEATH

Reg. Dist. No. 01776

|  |   |   |  |  |
|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>  |   | c. LENGTH OF STAY IN 1b<br><b>2 wks</b>   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Union Hospital</b>  |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural</b>  |  |  |
| f. STREET ADDRESS<br><b>Elkton</b>   |   | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><b>SARAH</b>   | Middle<br><b>SERESSA</b>  | Last<br><b>BOWLSBEY</b>  |  |
| 4. DATE OF DEATH   | Month<br><b>February</b>  | Day<br><b>20</b>  | Year<br><b>19 61</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 14, 1887</b>                         |  |
| 9. AGE (In years last birthday)<br><b>74</b>   | IF UNDER 1 YEAR<br>Months<br><b>74</b>  | IF UNDER 24 HRS.<br>Days<br><b>0</b>  | Hours<br><b>0</b>  | Min.<br><b>0</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |   |  |  |
| 13. FATHER'S NAME<br><b>Zain Bedwell</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Coude</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, or Unknown)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>218-14-8447</b>   | INFORMANT<br><b>Mr. Joseph W. Bowlsbey, R. D 3, Elkton</b>  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>162.1</b> DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c) |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>About 1 yr.</b>   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Generalized arteriosclerotic vascular disease</b>   |   | 19. WAS AUTOPSY<br>PERFORMED <input checked="" type="checkbox"/><br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br><b>Feb. 2</b>  | 20f. (City or town)<br><b>Elkton</b>                             | (County)<br><b>Elkton</b> (State)<br><b>Maryland</b>         |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above.   |   |   |  |  |
| ACTUAL<br>SIGNATURE<br><i>S. Ralph Andrews, Jr.</i>  | ADDRESS (Street, city or town, state)<br><b>233 E. Main Street</b>  |   |  | DATE SIGNED<br><b>2/20/61</b>                                |
| PHYSICIAN'S<br>NAME (Type)<br><b>S. Ralph Andrews, Jr., M.D.</b>   | Elkton, Maryland  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>2/23/61</b>   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Elkton Cemetery</b>  | 22d. LOCATION (City, town, or county)<br><b>Elkton, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Ralph E. Hicks</i>  | ADDRESS<br><b>Elkton, Maryland</b>  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 1 '61</b>   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Moore</i>             |  |



TO HOSPITAL  may be retained by hospital or attending physician.  
 TO FUNERAL DIRECTOR  After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



090

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |  |  |   |                  |  |            |   |   |  |                     |
|--|--|--|--|---|------------------|--|------------|---|---|--|---------------------|
| 1798 CERTIFICATE OF DEATH  |  |  |  |   |                  |  |            |   |   |  |                     |
|  |  |  |  |   |                  |  |            |   |   |  | Reg. Dist. No. 0177 |
| 1. PLACE OF DEATH<br>a. COUNTY Cecil MARYLAND  |  |  |  |   |                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Cecil |            |   |   |  |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Elikton  |  |  | c. LENGTH OF STAY IN lb  |   |                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Port Deposit, Rural                    |            |   | d. STREET ADDRESS   |  |                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Devine Nursing Home  |  |  |  |   |                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |            |   |   |  |                     |
| 3. NAME OF DECEASED (Type or print)  |  | First Florence                             | Middle Charsha   | last Brown  | 4. DATE OF DEATH |  | Month Feb. | Day 23                                  | Year 61   |  |                     |
| 5. SEX Female  |  | 6. COLOR OR RACE White                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 8. DATE OF BIRTH   |            | 9. AGE (In years last birthday) 81 yrs. |   | 10. IF UNDER 1 YEAR Months Days Hours Min. |                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House Wife  |  | 10b. KIND OF BUSINESS OR INDUSTRY Own Home |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |            |   |   |  |                     |
| 13. FATHER'S NAME James H. Charsha   |  |  |  |   |                  | 14. MOTHER'S MAIDEN NAME Elizabeth Reburn  |            |   |   |  |                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO  |  |  | 16. SOCIAL SECURITY NO. None   |   |                  | INFORMANT Wilmer E. Brown, Port Deposit, Md.   |            |   | Address   |  |                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Corony artery heart disease with severe angina pectoris<br>DUE TO<br>420.1<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydrated arteriosclerosis<br>DUE TO<br>(c) Unknown |  |  |  |   |                  |  |            |   |   |  |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |   |                  |  |            |   |   |  |                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)   |   |                  |  |            |   |   |  |                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.   |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> |   |                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |            |   | 20f. (City or town) (County) (State)  |  |                     |
| 21. I certify that I attended the deceased from <u>Dec 14, 1960</u> , to <u>Feb 23, 1961</u> , that I last saw the deceased alive on <u>Feb 22, 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.  |  |  |  |   |                  |  |            |   |   |  |                     |
| ACTUAL SIGNATURE <u>W.H. Thompson Jr.</u><br>PHYSICIAN'S NAME (Type) <u>Ralph A. Andrews Jr. M.D.</u>  |  |  |  |   |                  |  |            |   |   |  |                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  |  | 22b. DATE THEREOF <u>2-27-1961</u>   |   |                  | 22c. NAME OF CEMETERY OR CREMATORIAL <u>West Nottingham Cem.</u>   |            |   | 22d. LOCATION (City, town, or county) <u>Colora, Md.</u> (State) <u>Rural</u> |  |                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leva Patterson &amp; Son,</u>  |  |  |  |   |                  | ADDRESS <u>Perryville, Md.</u>   |            |   | 24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u><br>DATE <u>FEB 27 '61</u>     |  |                     |
|  |  |  |  |   |                  |  |            |   |   |  |                     |

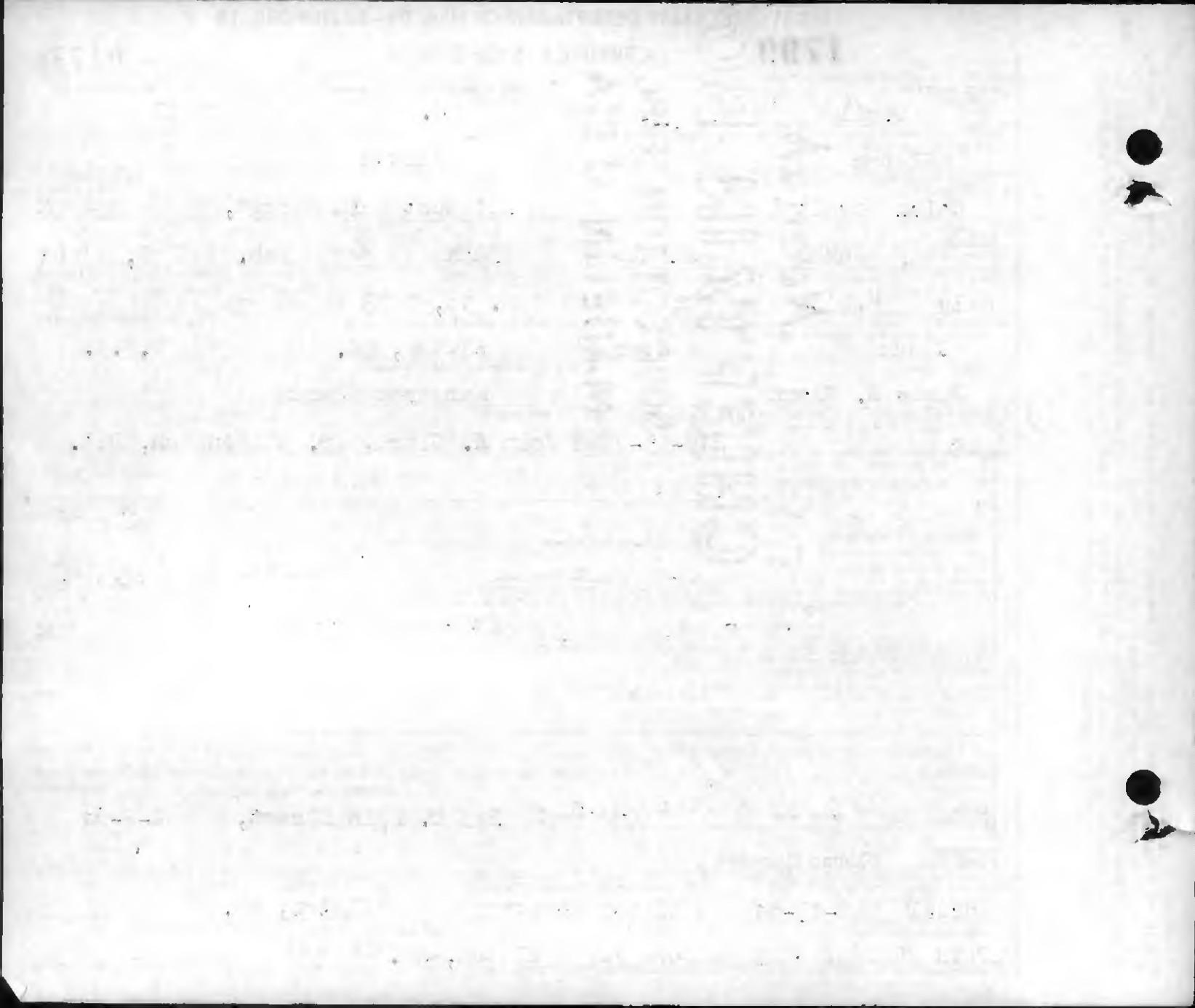
3071

1  
John Clark

**TO HOSPITAL** may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |  |   |   |   |   |  |   |   |   |  |  |  |  |   |  |  |
|---|--|--|---|---|---|---|--|---|---|---|--|--|--|--|---|--|--|
| 1799 CERTIFICATE OF DEATH   |  |  |   |   |   |   |  |   |   |   |  |  |  |  |   |  |  |
| Reg. Dist. No. 01778  |  |  |   |   |   |   |  |   |   |   |  |  |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b> |   |  |   |   |   |  |  |  |  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>   |  |  |   |   | c. LENGTH OF STAY IN lb<br><b>Life</b>  |   |  |   |   |   |  |  |  |  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Union Hospital</b>   |  |  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |   |  |   |   |   |  |  |  |  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First<br><b>JAMES</b>                                      | Middle<br><b>ALFRED</b>                           | Last<br><b>CLARK</b>  | 4. DATE OF DEATH<br><b>Feb. 9, 1961</b>   |   | Month Day Year   |   |   |   |  |  |  |  |   |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>                           |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>Jan. 18, 1873</b>                        |  | 9. AGE (In years lost birthday)<br><b>88 yrs.</b> |   |   |  |  |  |  |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Store</b> |   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Elkton, Md.</b> |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   |  |  |  |  |   |  |  |
| 13. FATHER'S NAME<br><b>James A. Clark</b>  |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Cannan</b>  |   |  |   |   |   |  |  |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  |  | 16. SOCIAL SECURITY NO.<br><b>216-03-7869</b>     |   |   | INFORMANT<br><b>John A. Clark, Jr. Wilmington, Del.</b>         |  |   | Address                                       |   |  |  |  |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>33 IX</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Malaria</b><br>(c) <b>Carcinoma of Prostate</b>  |  |  |   |   |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2-1/4</b>  |  |  |  |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>Prostatic Obstruction</b>   |  |  |   |   |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>19</b>       |   |  |   |   |   |  |  |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.   |  | Month<br><b>19</b>   | Day   | Year  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>       |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |   | 20f. (City or town)<br>(County) (State)   |  |  |  |  |   |  |  |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>265 W. Main Street, Elkton, Md.</b> |  |  |   |   |   |   |  |   |   | DATE SIGNED<br><b>2-9-61</b>  |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Glaucio Maresca</b>  |  |  |   |   |   |   |  |   |   |   |  |  |  |  |   |  |  |
| PHYSICIAN'S NAME (Type)   |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |   |   |   |   |  |   |   | 22b. DATE THEREOF<br><b>2-13-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Elkton Cemetery</b> |  |  | 22d. LOCATION (City, town, or county)<br><b>Elkton, Md.</b> |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>PIPPIN FUNERAL HOME</b>  |  |  |   |   |   |   |  |   |   | ADDRESS<br><b>Elkton, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>FEB 14 '61</b>                   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur G. Hause</b> |   |  |  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1800

## CERTIFICATE OF DEATH

Reg. Dist. No. 01279

|  |                           |   |   |  |   |  |  |                   |  |
|--|---------------------------|---|---|--|---|--|--|-------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Cecil  |                           | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Chesapeake City   |   | c. LENGTH OF STAY IN TB<br>4 weeks                                     |   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE<br>Maryland |  | b. COUNTY<br>Kent |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Morgans Nursing Home  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rock Hall   |   | d. STREET ADDRESS  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |                   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br>Thomas           | Middle<br>Nelson  | Last<br>Collyer   | 4. DATE<br>OF<br>DEATH<br>February                                     | Month<br>8  | Day<br>19  | Year<br>61                                   |                   |  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>April 19-1876   | 9. AGE (In years<br>less birthday)<br>04 yrs.                          | IF UNDER 1 YEAR<br>Months                         | IF UNDER 24 HRS.<br>Days   | Hours  | Min.              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Waterman  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br>Maryland                  |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |                   |  |
| 13. FATHER'S NAME<br>Thomas N. Collyer   |                           |   | 14. MOTHER'S MAIDEN NAME<br>Mary Jones  |  |   |  |  |                   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                           | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Mrs. Beaulah Collyer--Rock Hall, Md.                  |   | Address  |  |                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Waterman life long</i><br><br>DUE TO<br><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br><br>DUE TO<br><br>(c) _____   |                           |   |   |  |   |  |  |                   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br>1 year   |                           |   |   |  |   |  |  |                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |   |   |  |   |  |  |                   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |   |   |  |   |  |  |                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |  |  |                   |  |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.  | Month<br>19               | Day   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)                               | (County)   | (State)                                      |                   |  |
| 21. I certify that I attended the deceased from <i>Apr. 2, 1961</i> , to <i>Feb. 8, 1961</i> , that I last saw the deceased alive on <i>Feb. 8, 1961</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED<br>ACTUAL SIGNATURE <i>Henry V. Davis</i> M.D. <i>Feb. 10, 1961</i> |                           |   |   |  |   |  |  |                   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |                           | 22b. DATE THEREOF<br><i>Feb. 11</i>   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Wesley Chapel</i>           |   | 22d. LOCATION (City, town, or county)<br><i>Rock Hall</i> (State)<br><i>Maryland</i>                         |  |                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Edgar L. Jane</i>   |                           |   | ADDRESS<br><i>Church Hill, Maryland</i>   |  | 24a. REC'D BY REGISTRAR<br>DATE <i>FEB 10 '61</i> |  | 24b. REGISTRAR'S SIGNATURE<br><i>Calvert</i> |                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

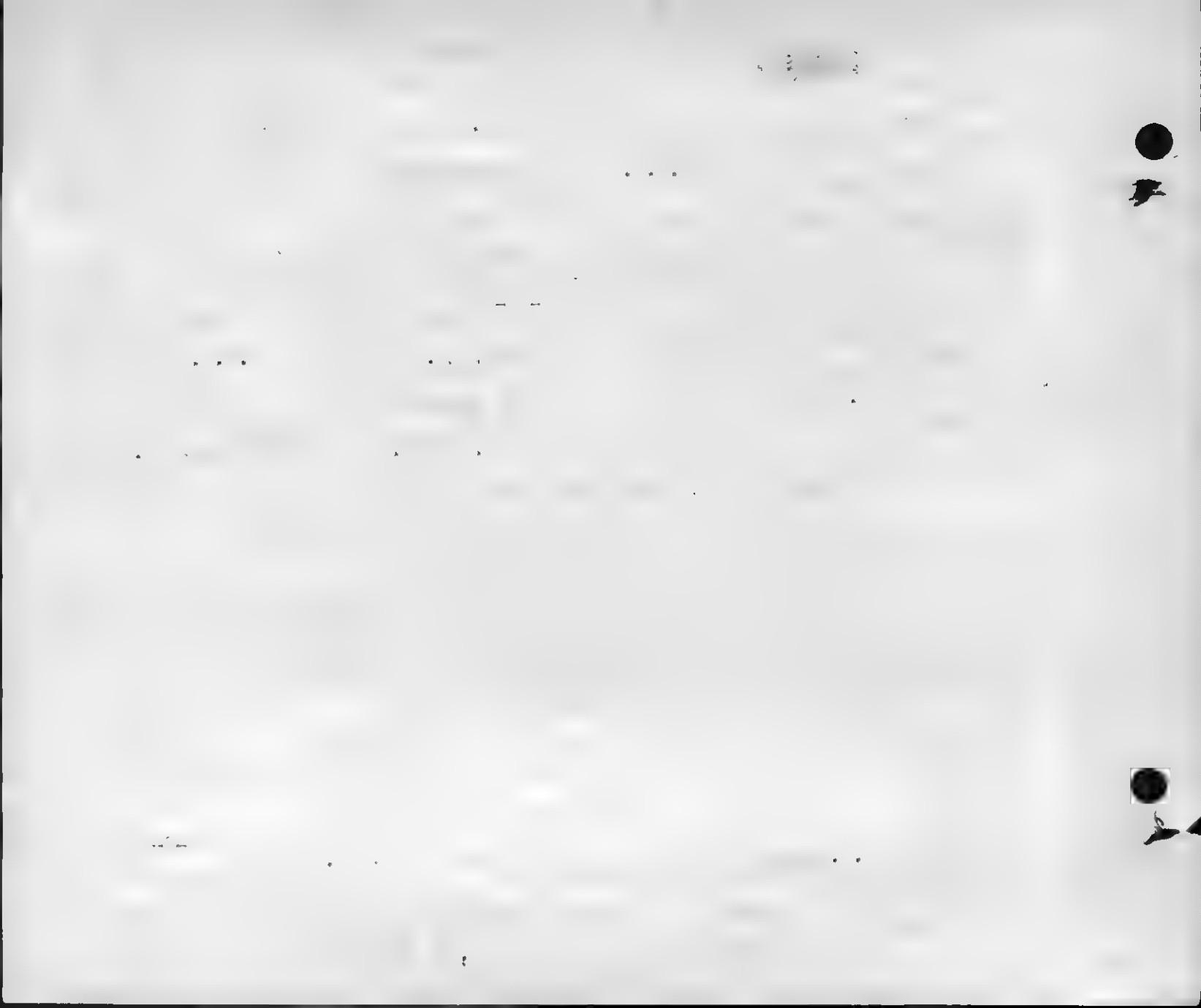
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01780

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>   |  | MARYLAND<br>c. LENGTH OF STAY IN lb<br><b>Elkton</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b>      |  | b. COUNTY<br><b>Cecil</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)             |  | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                                     |  | e. STREET ADDRESS<br><b>Chesapeake City</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Union Hosp.</b>   |  | D.O.A.<br><b>First</b>   |  | 4. DATE OF DEATH<br><b>Crain</b>   |  | f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mart in</b>   |  | Middle Name<br><b>Eugene</b>   |  | Lost<br><b>Crain</b>   |  | Month<br><b>2</b>  |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>W</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>                                |  | 8. DATE OF BIRTH<br><b>9-18-60</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Elkton, Md.</b>  |  | 9. AGE (In years less birthday) yrs.<br><b>4</b>   |  |
| 13. FATHER'S NAME<br><b>Wiley M. Crain</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lilly Burchan</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e) <b>X Pneumonia Bilateral</b><br><b>L+90X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)<br>DUE TO<br>(c)  |  | 17. INFORMANT<br><b>Wiley M. Crain, Chesapeake City, Md.</b>                                 |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) <b>Rising Sun, Md.</b>   |  | (County)   |  | (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br><b>R.C. Dodson</b>                        |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>MD.   |  | DATE SIGNED<br><b>2-2-61</b>   |  |
| ACTUAL SIGNATURE<br><b>R.C. Dodson</b>   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br><b>Rising Sun, Md.</b>                   |  | ADDRESS (Street, City, town, or county)  |  |  |  |
| EXAMINER'S NAME (Type)<br><b>R.C. Dodson</b>   |  | 22b. DATE THEREOF<br><b>2/4/1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Cherry Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Cherry Hill, Maryland</b>                         |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22e. ADDRESS   |  | 24a. REC'D BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>  |  |
| 23. FUNERAL DIRECTOR<br><b>PIPPY FUNERAL HOME</b>  |  | Elkton, Md.  |  | DATE <b>FEB 6 '61</b>  |  |  |  |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01781

1802

|   |  |  |   |   |   |  |                                 |   |
|---|--|--|---|---|---|--|---------------------------------|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |  | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Delaware</b>      |   | b. COUNTY  |                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Perry Point, Md.</b>   |  | c. LENGTH OF STAY IN lb<br><b>11mo. 20 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bear</b>                           |   | d. STREET ADDRESS<br><b>RFD #2</b>   |                                 |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |   | f. UNKNOWN   |                                 |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>GILBERT</b>  |  | First<br><b>M.</b>   | Middle<br><b>M.</b>   | Last<br><b>DIXON</b>  | 4. DATE OF DEATH<br><b>February 28 1961</b>       | Month  | Day                             | Year  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH<br><b>12-12-94</b>   | 9. AGE (In years lost birthday)<br><b>66 yrs.</b> | IF UNDER 1 YEAR<br><b>Months</b>   | IF UNDER 24 HRS.<br><b>Days</b> | Hours<br>Min.   |
| WIDOWED <input type="checkbox"/>  |  | DIVORCED <input type="checkbox"/>  |   |   |   |  |                                 |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |                                 |   |
| 13. FATHER'S NAME<br><b>John Dixon</b>  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Shahan</b>   |   |  |                                 |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>WW-L 215-20-1432</b>   |   | 17. INFORMANT<br><b>Hospital Records, VAH, Perry Point, Md.</b>   |   | Address  |                                 |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> unknown<br>DUE TO<br>(c) |  |  |   |   |   |  |                                 |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |   |   |  |                                 |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |   |   |   |  |                                 |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |                                 |   |
| 21. I certify that <b>A. L. Mooney</b> attended the deceased from <b>March 8 1961</b> to <b>February 28 1961</b> , <b>VAH</b> , <b>Perry Point, Md.</b> and that death occurred at <b>1:30 pm</b> M. from the causes and on the date stated above.  |  |  |   |   |   |  |                                 |   |
| 22a. SIGNATURE<br><b>A. L. Mooney</b>   |  |  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>3-1-61</b>  |                                 |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>   |  |  |   | 22d. ADDRESS  |   |  |                                 |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>3/3/61</b>   |  | 23b. DATE THEREOF<br><b>3/3/61</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Millington</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>Millington, Maryland</b> |                                 |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Remington &amp; Son, Havre de Grace, Md.</b>   |  |  |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 6 '61</b>                             |                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kline</b> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 may be required by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

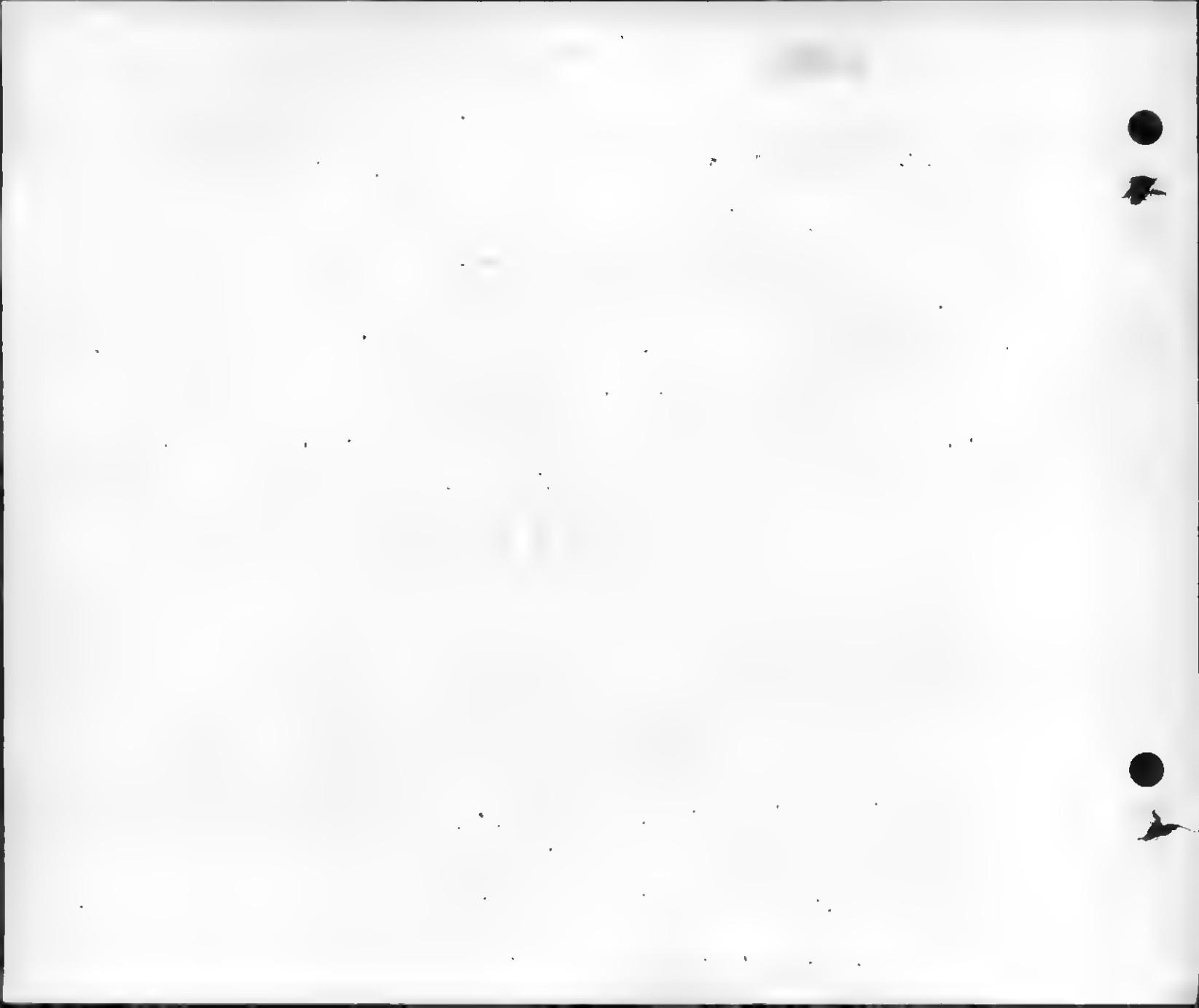
1803

## CERTIFICATE OF DEATH

Reg. Dist. No.

01782

|   |                                  |   |  |  |   |  |  |
|---|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Cecil</i>  |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Maryland</i> |   | b. COUNTY<br><i>Cecil</i>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Calvert</i>  |                                  | c. LENGTH OF STAY IN 1b<br>1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rising Sun</i>                |   | d. STREET ADDRESS<br><i>Cherry Street</i>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><i>Grosbeak Nursing Home</i>   |                                  |   |  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First<br><i>Mary</i>             | Middle<br><i>Alice</i>  | Last<br><i>Green</i>                   | 4. DATE<br>OF<br>DEATH<br><i>Feb. 7 1961</i>   | Month<br>Year                                   | Day  | Year   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Aug 6, 1884</i> | 9. AGE (In years<br>last birthday)<br><i>76 yrs.</i>   | 10. IF UNDER 1 YEAR<br>Months<br><i>76 yrs.</i> | 11. IF UNDER 24 HRS<br>Hours<br><i>0 hrs.</i>  | 12. IF UNDER 24 HRS<br>Min.<br><i>0 min.</i> |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><i>Dressmaker Housewife</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  |  | 10c. BIRTHPLACE (State or foreign country)<br><i>Pennsylvania</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 13. FATHER'S NAME<br><i>Albert Winters</i>  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Barbara Rhinehart</i>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>No</i>                                    |   | 16. SOCIAL SECURITY NO.<br>INFORMANT<br>Address<br><i>Genevieve Lockford Newark Del.</i> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic</i><br>DUE TO <i>High blood pressure</i><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first. <i>Arteriosclerosis</i><br>(b) <i>Arteriosclerotic</i><br>DUE TO <i>High blood pressure</i><br>(c) <i>Arteriosclerosis</i> |                                  |   |  |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)   |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour<br>o. m.<br>p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>2-1 1961</i> , to <i>2-7 1961</i> , that I last saw the deceased alive on <i>Feb 8 1961</i> , and that death occurred at <i>11:00 M</i> , from the causes and on the date stated above.  |                                  |   |  |  |   |  |  |
| ADDRESS (Street, city or town, state)<br><i>Port Deposit Md</i> DATE SIGNED<br><i>2-11-61</i>   |                                  |   |  |  |   |  |  |
| ACTUAL<br>SIGNATURE<br><i>R.C. Dodson MD</i>  |                                  | PHYSICIAN'S<br>NAME (Type)<br><i>R.C. Dodson MD</i>   |  |  |   |  |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>Feb 10, 1961</i>  |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Hopewell Cemetery</i>   |   | 22d. LOCATION (City, town, or county)<br>(State)<br><i>Port Deposit, Md</i>              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Ralph M. Reed, Rising Sun, Md</i>  |                                  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><i>FEB 9 '61</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>                                    |  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1804

## CERTIFICATE OF DEATH

Reg. Dist. No. 11782

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Cecil</i>  |  | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE<br><i>Maryland</i>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rising Sun</i>   |  | c. LENGTH OF STAY IN lb<br><i>life</i>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>OR INSTITUTION</i>   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rising Sun Md.</i>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Alma</i>   |  | 4. DATE OF DEATH<br>Month<br><i>February</i> Day<br><i>3</i> Year<br><i>1961</i>   |  |
| 5. SEX<br><i>Female</i>   |  | 6. COLOR OR RACE<br><i>White</i>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH<br><i>Aug. 6, 1877</i>  |  |
| WIDOWED <input type="checkbox"/>  |  | DIVORCED <input type="checkbox"/>  |  |
| 9. AGE (In years lost birthday)<br><i>83 yrs.</i>   |  | 10. UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Bookkeeper</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Bank</i>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 13. FATHER'S NAME<br><i>Henry C Keiholtz</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Mary H. Scott</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO<br><i>217-16-4398</i>   |  |
| 17. INFORMANT<br><i>Chalmers McFarran, Rising Sun, Md.</i>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>45x</i><br>DUE TO<br><i>High blood pressure</i>   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><i>High blood pressure</i>   |  |  |  |
| (c)   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>arteriosclerosis</i>  |  | 19. WAS AN AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><i>Injury occurred at home</i>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour<br>o. m.<br>p. m.<br><i>Feb. 6, 1961</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)   |  |
| 21. I certify that I attended the deceased from <i>1-4</i> , 19 <i>61</i> , to <i>2-3</i> , 19 <i>61</i> that I last saw the deceased alive on <i>2-2-61</i> , and that death occurred at <i>746 M</i> , from the causes and on the date stated above.<br>ACTUAL SIGNATURE<br><i>R. E. DODSON</i> |  | ADDRESS (Street, city or town, state)<br><i>Baltimore, Md.</i> DATE SIGNED<br><i>2-3-61</i>  |  |
| PHYSICIAN'S NAME (Type)<br><i>R. E. DODSON MD</i>   |  | 22a. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |
| 22b. DATE THEREOF<br><i>Feb. 6, 1961</i>  |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Hopewell Cemetery</i>   |  |
| 22d. LOCATION (City, town, or county)<br><i>Baltimore, Md.</i>  |  | (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Ralph M. Reed, Rising Sun, Md.</i>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><i>FEB 7 '61</i>  |  |
| ADDRESS   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Knott</i>   |  |



**TO HOSPITAL OR ENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours. Page 4 may be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**1805**

**CERTIFICATE OF DEATH**

01764

**1. PLACE OF DEATH**

a. COUNTY **Cecil** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Perry Point**  
c. LENGTH OF STAY IN 1b **5mo. 18days**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

**2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)**

a. STATE **Maryland** b. COUNTY **MONTGOMERY**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bethesda**

**3. NAME OF DECEASED**  
(Type or print)  
**WILLIAM R. KELLY**

**4. DATE OF DEATH**  
**February 20 1961**

**5. SEX** **Male** **6. COLOR OR RACE** **White** **7. MARRIED**  **NEVER MARRIED**   
**WIDOWED**  **DIVORCED**

**8. DATE OF BIRTH** **10-24-09**

**9. AGE (in years last birthday)** **51 yrs.** **IF UNDER 1 YEAR** **Months** **Days** **IF UNDER 24 HRS.** **Hours** **Min.**

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** **Dept. of Agriculture (Ret.) US Government** **10b. KIND OF BUSINESS OR INDUSTRY** **New York City**

**11. BIRTHPLACE (County & State, or foreign country)** **12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME** **Denis Kelly (deceased)** **14. MOTHER'S MAIDEN NAME** **Catherine Murray (deceased)**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give rank or dates of service]** **16. SOCIAL SECURITY NO.** **17. INFORMANT**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] **None Hospital Records, VAH, Perry Point, Md.**

**PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)** **491X** **DUE TO** **INTERVAL BETWEEN ONSET AND DEATH** **7 days**

**Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)** **Broncho pneumonia, bilateral unresolved**

**DUE TO** **(c)**

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)** **19. WAS AUTOPSY PERFORMED?**

**Degenerative cerebral disease (Alzheimer's disease)** **YES**  **NO**

**20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)** **20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)**

**20c. TIME OF INJURY** **Month, Day, Year** **20d. INJURY OCCURRED** **20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)** **20f. (City or town)** **(County)** **(State)**

**Hour e.m.** **WHILE AT WORK** **Not WHILE AT WORK** **20f. (City or town)** **(County)** **(State)**

**p.m.** **VA** **19** **20f. (City or town)** **(County)** **(State)**

**21. I certify that [REDACTED] attended the deceased from September 2 1960, February 20 1961, [REDACTED] and that death occurred at 10:15 a.m. on the causes and on the date stated above.**

**22a. SIGNATURE** **A.L. Mooney** **22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME (Type)** **A.L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.**

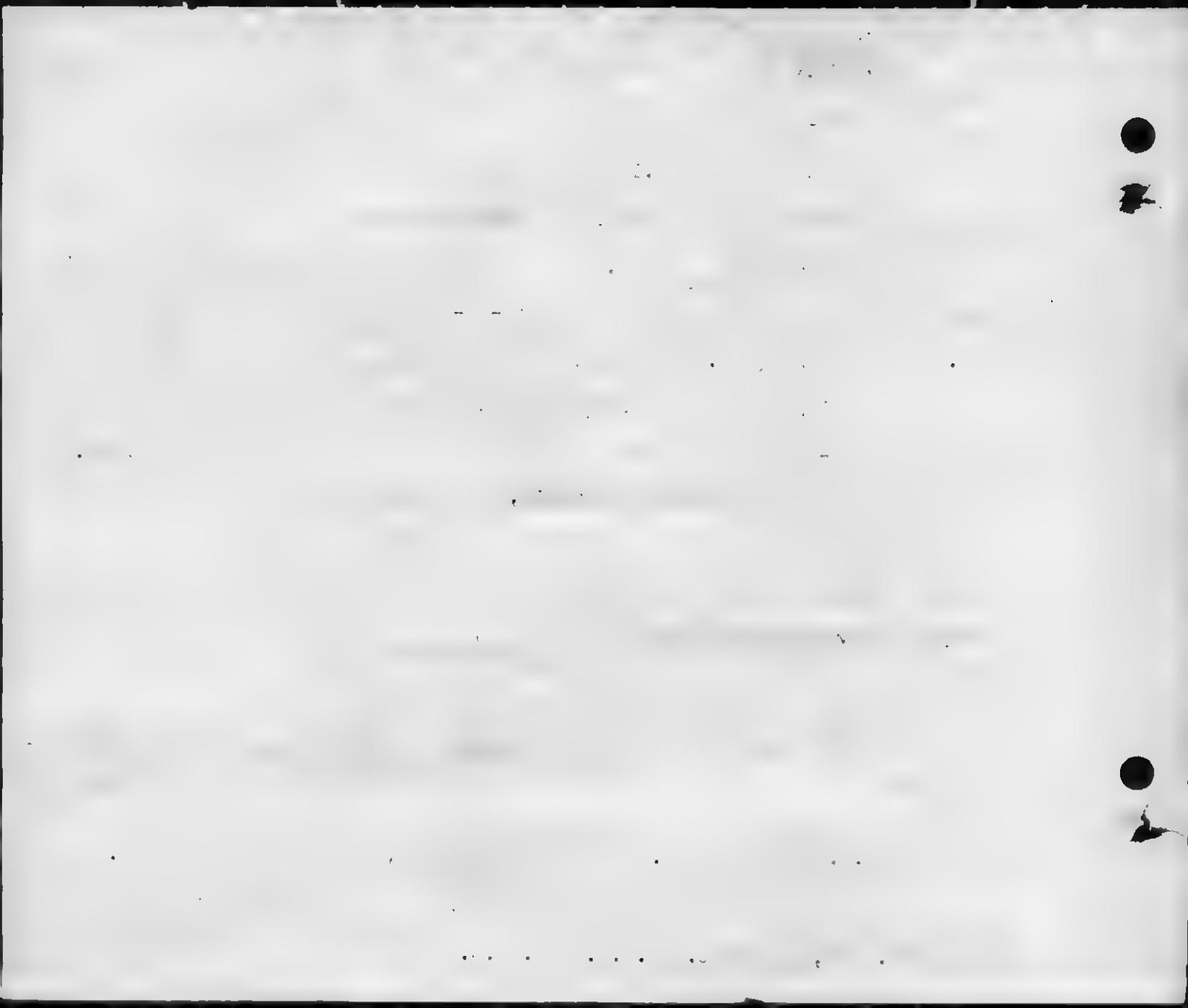
**23a. BURIAL, CREMATION, REMOVAL (Specify)** **24. FUNERAL DIRECTOR'S SIGNATURE** **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE**

**BURIAL** **24766 1961** **DE VOL' FUN. HOME, 2224 Wisc. Ave. N.W. Wash. D.C.** **FEB 27 '61** **Ollie S. Thrus**

**23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS** **23d. LOCATION (City, town or county)** **(State)**

**Arlington National** **Arlington, Virginia**

**25c. DATE**



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1806

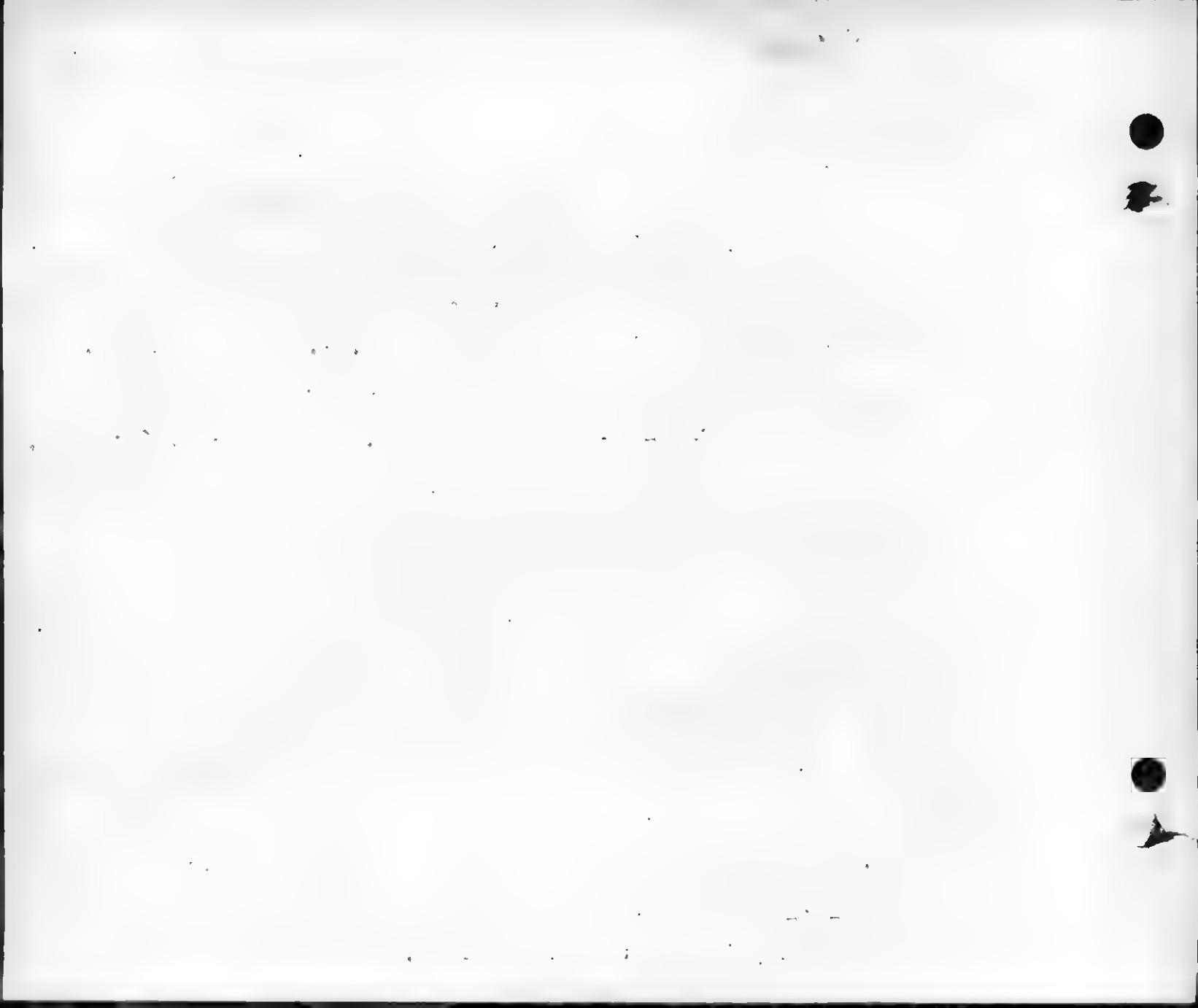
## CERTIFICATE OF DEATH

Reg. Dist. No. 1785

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |   |  |   |  |   |                                     |                     |
|--|----------------------------------|---|--|---|--|---|-------------------------------------|---------------------|
| PLACE OF DEATH<br>a. COUNTY<br><i>Cecil</i>  |                                  | MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE<br><i>Maryland</i> |  | b. COUNTY<br><i>Cecil</i>   |                                     |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Hollywood Beach</i>   |                                  | c. LENGTH OF STAY IN 1b<br><i>20 years</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Cheasapeake City</i>       |  | d. STREET ADDRESS<br><i>Hollywood Beach</i>   |                                     |                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  |   |  | d. STREET ADDRESS   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |                     |
| 3. NAME OF DECEASED (Type or print)  |                                  | First<br><i>Raymond C</i>   | Middle<br><i>martin</i>  | Last<br><i>martin</i>   | 4. DATE OF DEATH<br><i>Feb. 17 1961</i>          | Month<br><i>Feb.</i>  | Day<br><i>17</i>                    | Year<br><i>1961</i> |
| S SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                             | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><i>Nov. 6, 1894</i>   | 9 AGE (In years lost birthday)<br><i>66 yrs.</i> | IF UNDER 1 YEAR<br>Months<br><i>0</i>   | IF UNDER 24 HRS<br>Days<br><i>0</i> |                     |
| 10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Motor Court Operator</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Motel</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Buffalo, N. Y.</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                                     |                     |
| 13. FATHER'S NAME<br><i>William Martin</i>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Mattie Greggor</i>   |  |   |                                     |                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO<br><i>222-10-2248</i>  |  | INFORMANT<br><i>Mrs. Kathryn M. Martin, Ches. City, Md.</i>   |  | Address   |                                     |                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Carcinoma of Lung.</i>   |                                  |   |  |   |  |   |                                     |                     |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)   |                                  |   |  |   |  |   |                                     |                     |
| INTERVAL BETWEEN ONSET AND DEATH<br><i>3 mos</i>   |                                  |   |  |   |  |   |                                     |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><i>Hepatic metastases; poss Ca of Stomach.</i>   |                                  |   |  |   |  |   |                                     |                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>11:00 P.M.</i> |  |   |  |   |                                     |                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m.<br>p. m.<br><i>Nov 19 60 19</i>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>         |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | (County) (State)  |                                     |                     |
| 21. I certify that I attended the deceased from <i>Nov 19 60</i> , to <i>Feb 17 1961</i> , that I last saw the deceased alive on <i>Feb 17 1961</i> , and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above. |                                  |   |  |   |  |   |                                     |                     |
| ADDRESS (Street, city or town, state)<br><i>Cecilton, Maryland</i>   |                                  |   |  |   |  |   |                                     |                     |
| DATE SIGNED<br><i>18 Feb 61</i>  |                                  |   |  |   |  |   |                                     |                     |
| ACTUAL SIGNATURE<br><i>Wallace Obenshain</i> M.D.  |                                  |   |  |   |  |   |                                     |                     |
| PHYSICIAN'S NAME (Type)<br><i>Dr. Wallace Obenshain</i>  |                                  |   |  |   |  |   |                                     |                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>2-21-61</i>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Fairview Cemetery</i>  |  | 22d. LOCATION (City, town, or county) (State)<br><i>Freeburg, Penna.</i>                          |                                     |                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>PIPPIN FUNERAL HOME</i>   |                                  | ADDRESS<br><i>Elkton,</i>   |  | 24a. REC'D BY REGISTRAR<br><i>MEEB 21 '61</i>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kline</i>  |                                     |                     |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

**1807**

01286

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>CENTRAL</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>—</b>   |  | c. LENGTH OF STAY IN 1b<br><b>7 yrs.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>—</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>John J. Compton</b>   | First<br><b>J</b>  | Middle<br><b>J</b>  | Last<br><b>Compton</b>  |
| 4. DATE OF DEATH<br><b>2/1/1961</b>  | Month<br><b>2</b>  | Day<br><b>1</b>   | Year<br><b>1961</b>   |
| 5. SEX<br><b>F.</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/12/1898</b>   |
| 9. AGE (In years last birthday)<br><b>62</b>   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Hospitality</b> | 11. KIND OF BUSINESS OR INDUSTRY<br><b>On Home</b>  | 12. BIRTHPLACE (State or foreign country)<br><b>Va.</b>   |
| 13. FATHER'S NAME<br><b>George Compton</b>   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Yates</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)<br><b>No</b>  | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT<br><b>Thomas Kardonov</b>   | Address<br><b>Conowingo, Md., 1-813</b>   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br><br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)<br><b>443</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><b>Hypertension, Cardio Vascular disease</b><br>(c)<br>DUE TO<br><b>Mesenteric Thrombosis</b><br>DUE TO<br><b>Paroxysmic Attacks</b> |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>8 yrs.</b>  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1955, to 2-1, 1961</b> , that (I) (we) last saw the deceased alive on <b>2-1, 1961</b> , and that death occurred at <b>at home</b> M, from the causes and on the date stated above  |  |   |   |
| 22a. SIGNATURE<br><b>G. H. Richards Jr.</b>  |  | 22b. DATE SIGNED<br><b>3/2/61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>G. H. Richards Jr.</b>  |  | 22d. ADDRESS<br><b>Port Deposit Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>2/5/1961</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Conowingo Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Conowingo</b>   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>James E. McMullen</b>   |  | ADDRESS<br><b>Rt. 1 in Sun., ...</b>  | 25a. REC'D BY REGISTRAR<br><b>Conowingo</b>   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Krause</b>  | DATE FEB 7 '61  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1808

## CERTIFICATE OF DEATH

Reg. Dist. No 011787

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Cecil</i>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Md.</i>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>EKTON</i>   | c. LENGTH OF STAY IN lb   | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>EKTON</i>  | b. COUNTY<br><i>Cecil</i>  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Union Memorial</i>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><i>Florence</i>  | Middle<br><i>Holitor</i>  | 4. DATE OF DEATH<br>Month<br><i>Feb</i> Day<br><i>17</i> Year<br><i>1961</i> |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>W</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Dec. 9, 1888</i>                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>  | 9. AGE (In years last birthday)<br><i>72 yrs</i>                             |
| 13. FATHER'S NAME<br><i>William Brown</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Florence McIntire</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown)<br><i>No</i>  | 16. SOCIAL SECURITY NO.<br><i>- - -</i>   | INFORMANT<br><i>Jean Bullock, Pleasant Hill, Md.</i>  | Address<br><i>Pleasant Hill, Md.</i>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |   |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Uremia</i>  |   |   |  |
| 260X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Diabetic nephropathy</i>   |   |   |  |
| Years<br><i>2 weeks</i>  |   |   |  |
| DUE TO<br>(c) <i>Diabetes mellitus</i>   |   |   |  |
| Years<br><i>Years</i>  |   |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)   |   |   |  |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.<br>19  | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br>(County)<br>(State)                                   |
| 21. I certify that I attended the deceased from <i>Feb 13, 1961</i> , to <i>Feb 17, 1961</i> , that I last saw the deceased alive on <i>Feb 17, 1961</i> , and that death occurred at <i>2:10 P.M.</i> from the causes and on the date stated above. |   |   |  |
| ACTUAL SIGNATURE<br><i>Florence Brown</i>  | M.D.  | ADDRESS (Street, city or town, state)<br><i>23 Sinskey Ave 2-17-61</i>  | DATE SIGNED<br><i>2-17-61</i>  |
| PHYSICIAN'S NAME (Type)<br><i>Florence D. Johnson</i>  | EKTON, Md.  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   | 22b. DATE THEREOF<br><i>2/20/61</i>   | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Cherry Hill Meth Cherry Hill, Md.</i>  | 22d. LOCATION (City, town, or county)<br>(State)<br><i>Cherry Hill, Md.</i>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Ralph E. Hicks Elkhorn, Md.</i>   | ADDRESS<br><i>Elkhorn, Md.</i>  | 24a. REC'D BY REGISTRAR<br>DATE<br><i>MAR 1 '61</i>   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>                        |

2. 70

**TO HOSPITAL DIRECTOR:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in by me funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

01788

1809

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Cecil  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><br>MARYLAND Maryland |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Perry Point  |  | c. LENGTH OF STAY IN lb<br>32 yrs. 3 mo. 21 days Baltimore  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>Veterans Administration Hospital   |  | e. STREET ADDRESS<br>412 N. Haven   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>KENNETH  |  | First L.  | Middle Last<br>MORGAN                  |
| 4. DATE OF DEATH<br>February 1 1961  | Month Day Year                             |   |  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White                  | 7. MARRIED<br>WIDOWED   | NEVER MARRIED<br>DIVORCED              |
| 8. DATE OF BIRTH<br>2-3-01   | 9. AGE (In years last birthday)<br>59 yrs. | 10. IF UNDER 1 YEAR<br>Months   | 11. IF UNDER 24 HRS<br>Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Miner   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Coal Mine  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Pennsylvania  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Herman Morgan   |  | 14. MOTHER'S MAIDEN NAME<br>Clara London  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>Yes  |  | 16. SOCIAL SECURITY NO.<br>WW-I None  |  |
| 17. INFORMANT<br>Hospital Records, VAH, Perry Point, Md.   |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><br>163 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 minutes<br><br>Hemorrhage pulmonary   |  |
| DUE TO<br>Carcinoma of the lung<br>(c)   |  | Approx.<br>3 years  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                              |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                 |  |
| 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| VA   |  | October 11, 1960 to February 1, 1961  |  |
| 21. I certify that <del>E.S. Ells</del> attended the deceased from October 11, 1960 to February 1, 1961, <del>and that death occurred at</del> <del>9:30 A.M.</del>  |  | 22b. DATE SIGNED<br>2-1-61  |  |
| 22a. SIGNATURE<br><i>E.S. Ells,</i>  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |
| 22c. PHYSICIAN'S NAME (Type)<br>E.S. ELLS, Chief, Continued Treatment Service, VAH, Perry Point, Md.   |  | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br>Burial   |  | 23b. DATE THEREOF<br>2/3/61   |  |
| 23c. NAME OF CEMETERY OR CREMATORIAL<br>Baltimore National   |  | 23d. LOCATION (City, town, or county)<br>Baltimore, Maryland (State)  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Schimunek Funeral Home, Baltimore, Md.   |  | ADDRESS   |  |
|  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 3 '61   |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><i>E.S. Ells</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

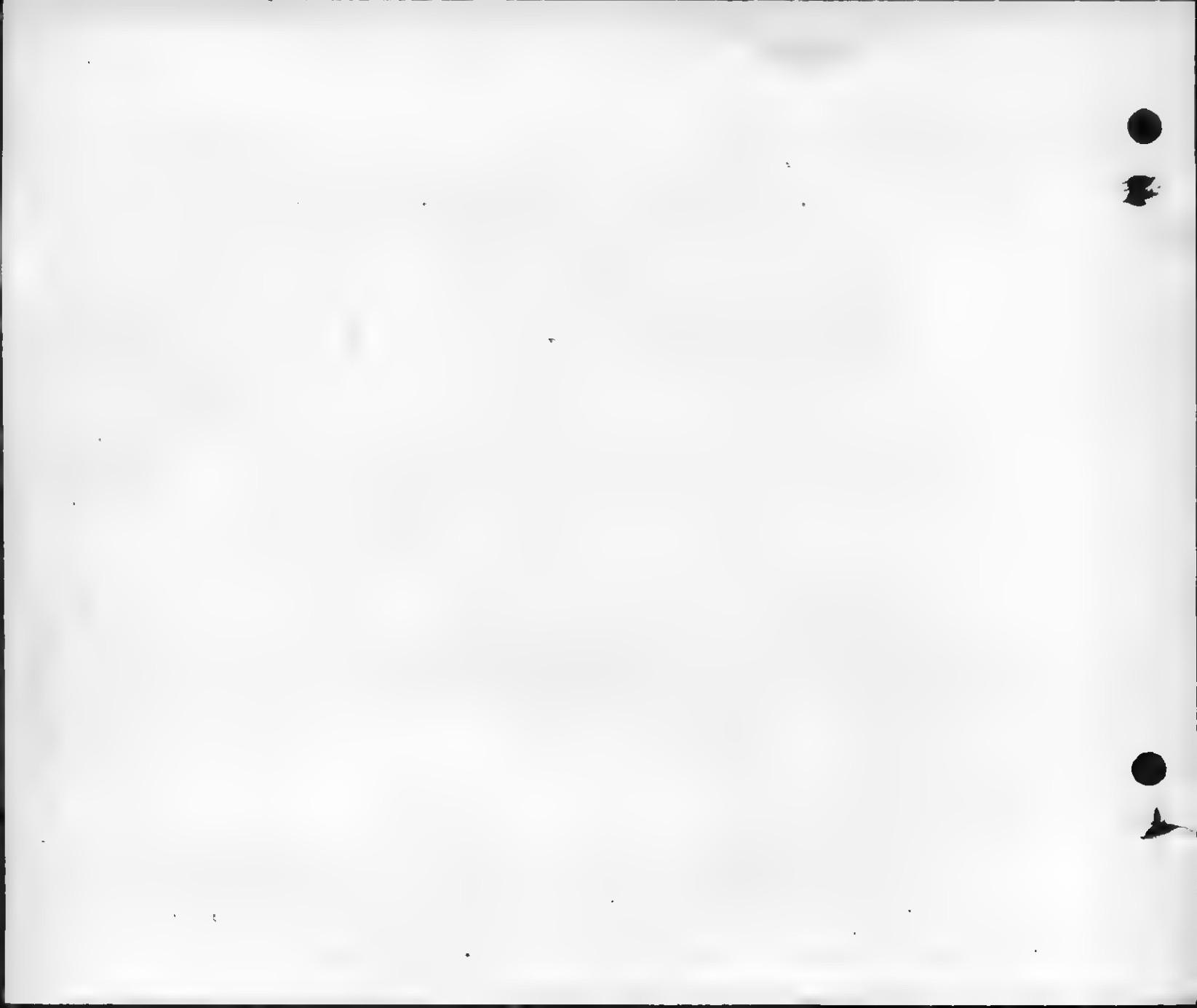
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1810

**CERTIFICATE OF DEATH**

01783

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>                                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Port Deposit</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>Port Deposit</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>73<sup>1</sup> S. Main St.</b>  |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>73<sup>1</sup> S. Main St.</b>                                       |   |
| f. STREET ADDRESS  |                                  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Grace</b>   |                                  | First<br><b>A.</b>  | Middle<br><b>Musselman</b>  |
|  |                                  | Last<br><b>Elizabeth</b>  | 4. DATE OF DEATH<br>Month<br><b>Feb.</b> Day<br><b>23</b> Year<br><b>1961</b>                                 |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 8, 1895</b>   |
| 9. AGE (In years last birthday)<br><b>66 yrs</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>06</b>  | 11. IF UNDER 24 HRS<br>Hours<br><b>00</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House keeper</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Penns.</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>David H. Musselman</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth</b>   |                                  | 15. INFORMANT<br><b>Mrs Fredrick Felpel, Port Deposit, Md</b>   |   |
| 16. CAUSE OF DEATH [Enter only one cause per line for (b), and (c)]<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br><br><b>16 IX</b><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last<br><br>DUE TO<br><br>(b) |                                  | 17. INTERVAL BETWEEN<br>ONSET AND DEATH<br><br><i>Coronary Larynx</i><br><b>1/2 yrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |                                  | 18. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><br><i>Oct. 1960, to 3d 22 1961</i> |
| 20f. (City or town)<br><br><i>Port Deposit, Md</i>   |                                  | (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____ and that death occurred at _____ M. from the causes and on the date stated above  |                                  | 22b. DATE SIGNED<br><br><i>Feb 23 1961</i>  |   |
| 22a. SIGNATURE<br><br><i>Clarence I. Benson</i>  |                                  | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>                                | 22d. ADDRESS<br><br><i>Port Deposit, Md</i>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Clarence I. Benson</b>  |                                  | 23d. LOCATION (City, town, or county)<br><br><i>Quarryville, Pa.</i>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>2-25-1961</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Quarryville Cem.</b>   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><br><i>Vera Patterson &amp; Son</i>  |                                  | ADDRESS<br><br><i>Perryville, Md.</i>   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 23 '61</b>  |
|  |                                  |   | 25b. REGISTRAR'S SIGNATURE<br><br><i>Arthur S. Head</i>   |



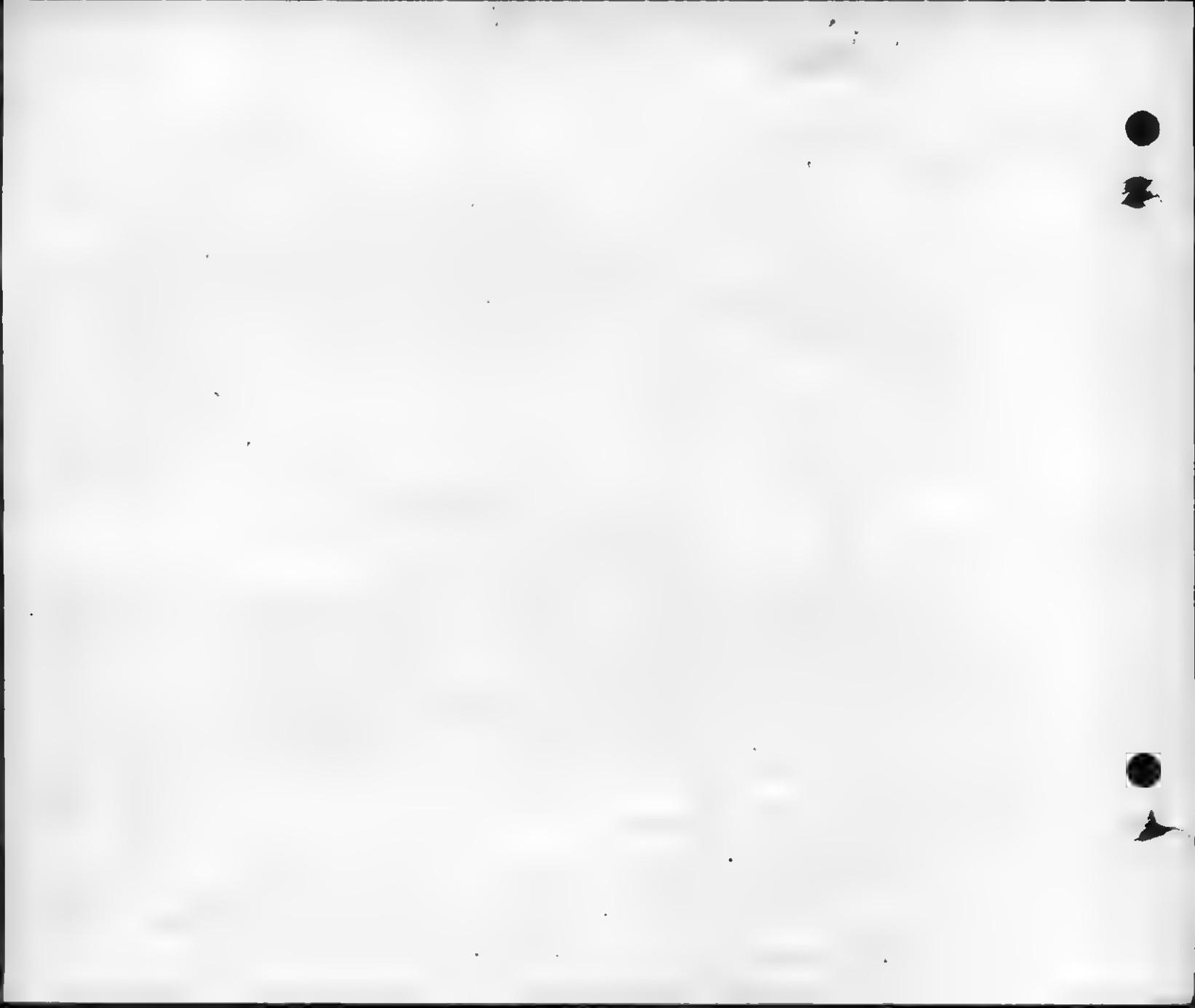
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1811

**CERTIFICATE OF DEATH**

01790

|   |                                    |   |  |  |   |
|---|------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Port Deposit, Rural</b>  |                                    | c. LENGTH OF STAY IN 1b<br><b>58 yrs</b>  |  | b. COUNTY<br><b>Cecil</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Mt. Ararat Farms</b>  |                                    | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Port Deposit, Rural</b>  |  | f. STREET ADDRESS<br><b>Mt. Ararat Farms</b>   |   |
| g. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    |   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br><b>Mary</b>               | Middle<br><b>Hannah</b>   | Last<br><b>Pitt</b>                      | 4. DATE OF DEATH<br>Month<br><b>Feb.</b> Day<br><b>23</b> Year<br><b>19 61</b>   |   |
| S. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 14, 1881</b> | 9. AGE (In years last birthday)<br><b>80</b> yrs   | IF UNDER 1 YEAR<br>Months<br><b>0</b> Days<br><b>0</b> Hours<br><b>0</b> Min<br>IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Housewife</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ovn Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |                                    |   |  |  |   |
| 13. FATHER'S NAME<br><b>Henry</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Marcellena</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Address<br>(Yes, no, unknown) (If yes, give war or dates of serv.)<br><b>No</b> |   |
| 16. SOCIAL SECURITY NO.<br><b>212-32-1654</b>   |                                    | 17. INFORMANT<br><b>Mrs Alexander Williams, Port Deposit, Md</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>59</b>  |                                    | DUE TO<br><b>Chronic Nephritis -</b>  |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>5 yrs</b>  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>(b)<br>DUE TO<br>(c)   |                                    |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic Myocarditis -</b>  |                                    |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><b>Not - No 1959 to Feb 22 1961</b>                          |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o m<br>p m<br><b>19</b>  |                                    | 20d. INJURY OCCURRED<br>White Not white<br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Port Deposit, Md.</b>                           |   |
| 20f. (City or town)<br><b>Port Deposit, Md.</b>   |                                    | (County)<br><b>0</b>  |  | (State)<br><b>0</b>  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov - Nov 1959</b> to <b>Feb 22 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 22 1961</b> , and that death occurred at <b>Port Deposit, Md.</b> from the causes and on the date stated above. |                                    |   |  |  |   |
| 22a. SIGNATURE<br><b>Clarence J. Penson</b>   |                                    | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>Feb 28 1961</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Clarence J. Penson</b>   |                                    | 22d. ADDRESS<br><b>Port Deposit, Md.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, DISPOSAL (Specify)<br><b>Burial</b>   |                                    | 23b. DATE THEREOF<br><b>2-26-1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Cokesbury Cen.</b>  |   |
| 23d. LOCATION (City, town, or county)<br><b>Port Deposit, Md. Rural</b>   |                                    |   |  |  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Lev Patterson &amp; Son,</b>   |                                    | ADDRESS<br><b>Perryville, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 28 '61</b>  |   |
|   |                                    |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Clarence J. Penson</b>  |   |



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. (11291)

**1812**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |  | MARYLAND                                   |  | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)<br>a. STATE<br><b>Md.</b> |  | b. COUNTY<br><b>Cecil</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>North East Rural</b> |  | c. LENGTH OF STAY IN lb<br><b>all life</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>North East Rural</b>    |  | d. STREET ADDRESS   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)                                |  |  |  | d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |

|   |                        |                           |      |                        |                   |                  |                     |
|---|------------------------|---------------------------|------|------------------------|-------------------|------------------|---------------------|
| 3. NAME OF<br>DECEASED<br>(Type or print) | First<br><b>Thomas</b> | Middle<br><b>Pressley</b> | Last | 4. DATE<br>OF<br>DEATH | Month<br><b>2</b> | Day<br><b>15</b> | Year<br><b>1961</b> |
|---|------------------------|---------------------------|------|------------------------|-------------------|------------------|---------------------|

|                    |                              |   |                                      |   |  |   |  |          |
|--------------------|------------------------------|---|--------------------------------------|---|--|---|--|----------|
| 5. SEX<br><b>M</b> | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-20-1947</b> | 9. AGE (In years<br>last birthday)<br><b>13</b><br>yrs. | 10. UNDER 1 YEAR<br>Months<br><b>0</b> | 11. IF UNDER 24 HRS<br>Days<br><b>0</b> | 12. IF UNDER 24 HRS<br>Hours<br><b>0</b> | 13. MIN. |
|--------------------|------------------------------|---|--------------------------------------|---|--|---|--|----------|

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Child</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
|---|-----------------------------------|---|---|

|  |   |
|--|---|
| 13. FATHER'S NAME<br><b>Talby Pressley</b> | 14. MOTHER'S MAIDEN NAME<br><b>Ollie Lee Crabtree</b> |
|--|---|

|  |                                  |  |                                   |
|--|----------------------------------|--|-----------------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br>----- | 17. INFORMANT<br><b>Talby Pressley</b> | Address<br><b>North East, Md.</b> |
|--|----------------------------------|--|-----------------------------------|

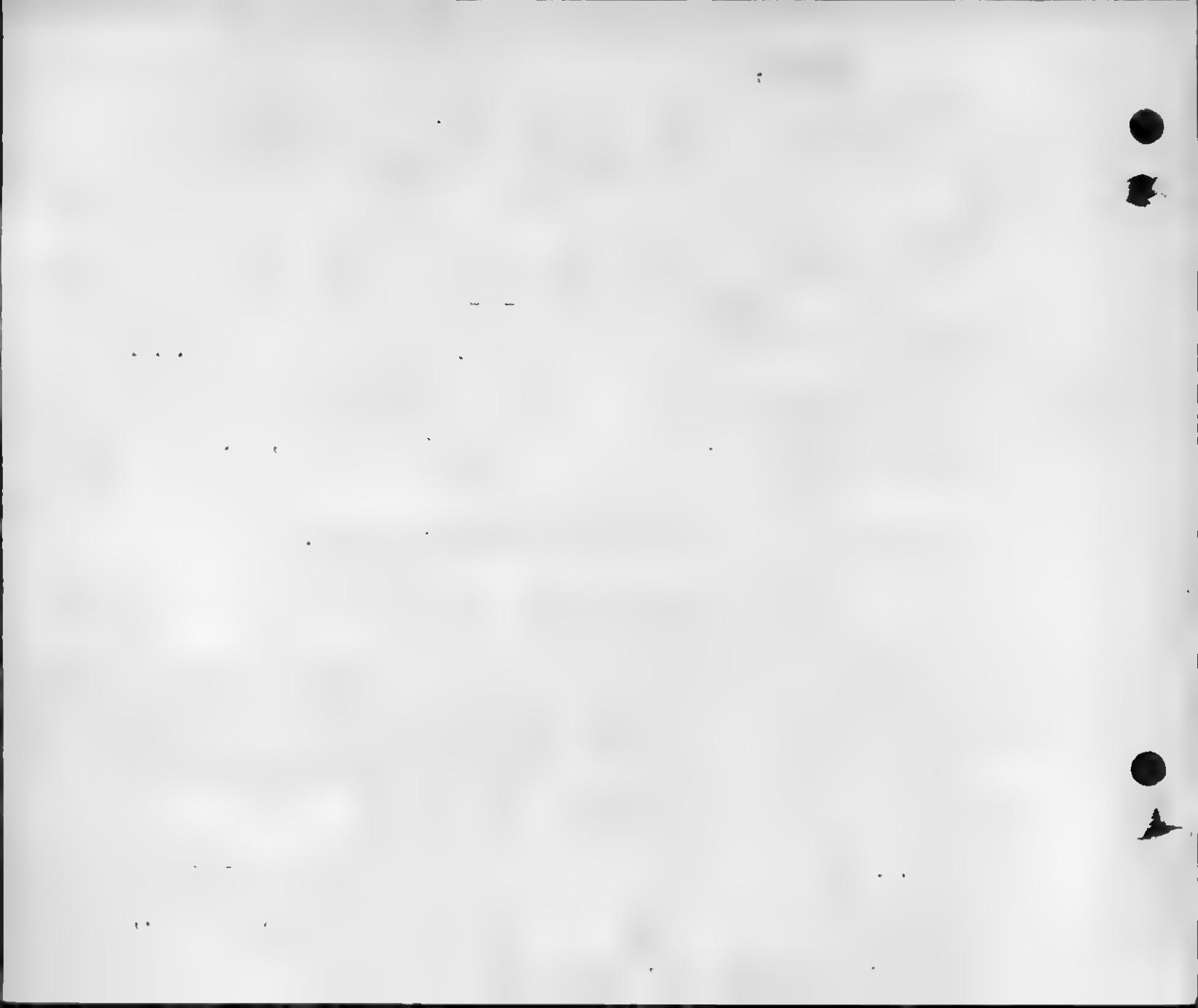
|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  | INTERVAL BETWEEN<br>ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>   |  |  |
| DUE TO<br><br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause first.<br><br>(b) <b>Epilepsy and deformity since birth.</b> |  |  |
| DUE TO<br><br>(c)  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

|  |  |   |  |
|--|--|---|--|
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |  |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.  | Month, Day, Year<br>19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |  |  |
|---|--|--|--|--|--|

|   |   |                               |
|---|---|-------------------------------|
| ACTUAL<br>SIGNATURE<br><br>EXAMINER'S<br>NAME (Type)<br><b>R.C.Dodson</b> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | DATE SIGNED<br><b>2-16-61</b> |
|---|---|-------------------------------|

|  |  |  |  |
|--|--|--|--|
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>2-18-1961</b>  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Methodist</b> | 22d. LOCATION (City, town, or county)<br><b>North East, Cecil Co., Maryland</b><br>(State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><br><b>Joseph R. Grant</b> | ADDRESS<br><b>North East, Maryland</b> | 24a. REC'D BY REGISTRAR<br><b>FEB 20 '61</b>             | 24b. REGISTRAR'S SIGNATURE<br><b>John L. Fine</b>  |

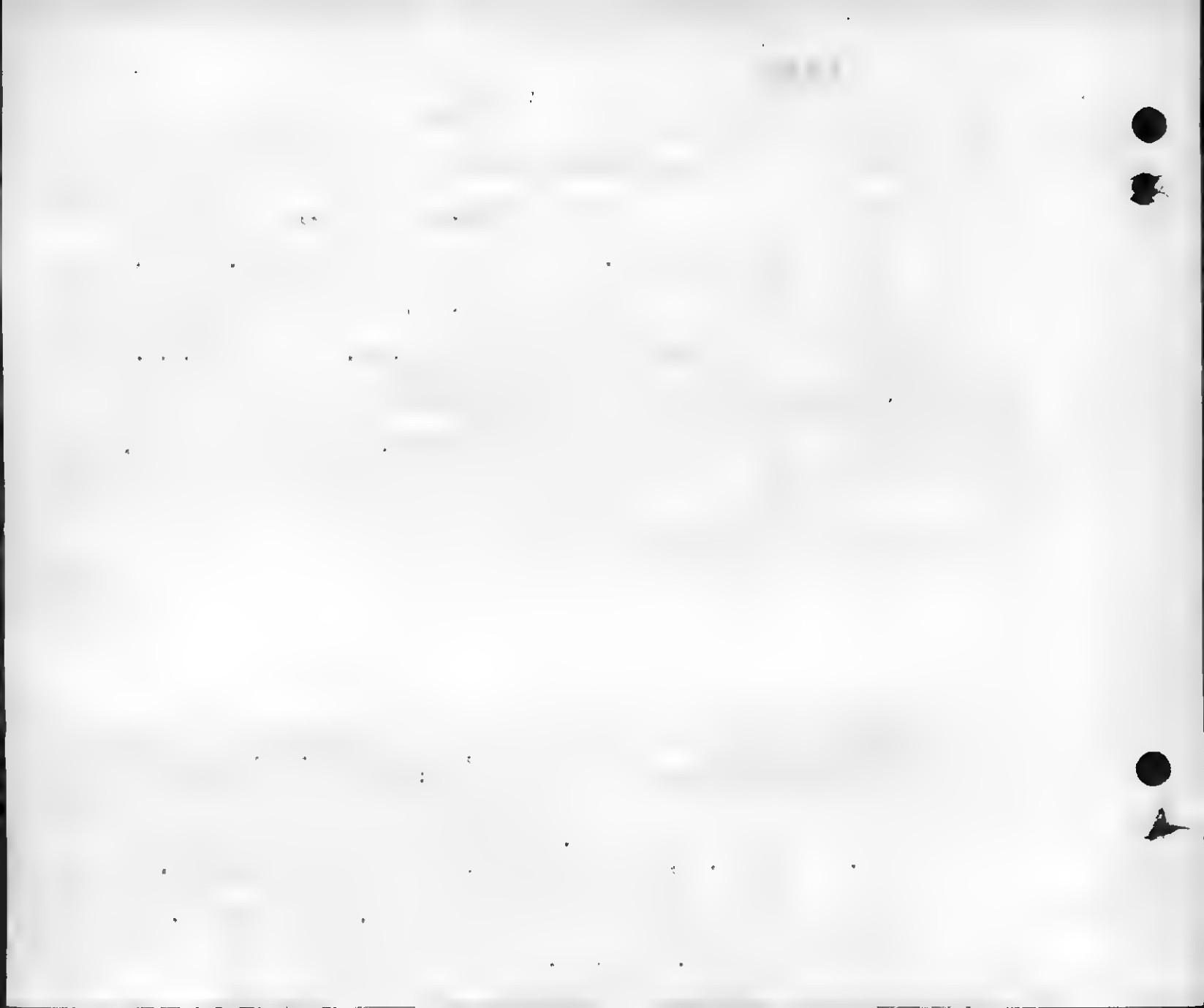


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1813

01792

|   |  |   |   |  |  |   |     |  |  |
|---|--|---|---|--|--|---|-----|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY   |     |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Perry Point</b>  |  | c. LENGTH OF STAY IN 1b<br><b>35yr3mo26days</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                 |  | d. STREET ADDRESS<br><b>913 N. Fulton Ave.</b>  |     |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Hospital</b>  |  |   |   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |     |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>EMMITT G. ROBERTSON</b>   |  | First   | Middle  | Last   | 4. DATE OF DEATH<br><b>Feb. 18, 1961</b>         | Month   | Day | Year   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 24, 1887</b>   | 9. AGE (In years last birthday)<br><b>73</b> yrs | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>                 |     | IF UNDER 24 HRS.<br>11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bookkeeper</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>   |   | 11. COUNTRY OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |   |     |  |  |
| 13. FATHER'S NAME<br><b>Nathan E. Robertson</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Young</b>  |   |  |  |   |     |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>WV1 None</b>  |   | 17. INFORMANT<br><b>Hospital Records, VAH, Perry Point, Md.</b>  |  | Address   |     |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Coronary thrombosis</b>   |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 minute</b>   |     |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>420</b>  |  |   |   |  |  |   |     |  |  |
| (b)<br>DUE TO<br><b>Atherosclerotic heart disease</b>   |  |   |   |  |  | Unknown   |     |  |  |
| (c)<br>DUE TO   |  |   |   |  |  |   |     |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)    |   |  |  |   |     |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m. <b>VA</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br>(County)<br>(State)  |     |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (hospital) attended the deceased from <b>July 26, 1925</b> to <b>Feb. 18, 1961</b> , and that death occurred at <b>4:50PM</b> from the causes and on the date stated above |  |   |   |  |  |   |     |  |  |
| 22a. SIGNATURE<br><b>Albert L. Mooney</b>   |  | M.D. ATTENDING PHYS <input type="checkbox"/><br>Asst. Clinic <input type="checkbox"/>           |   | MED DIRECTOR <input type="checkbox"/><br>STAFF PHYS <input checked="" type="checkbox"/>                              |  | 22b. DATE SIGNED<br><b>2-19-61</b>  |     |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ALBERT L. MOONEY, M.D., Pathologist</b>  |  | VAH, Perry Point, Maryland.   |   |  |  |   |     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE THEREOF<br><b>2/25/61</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Arlington National</b>  |  | 23d. LOCATION (City, town, or county)<br><b>Ft. Myer, Virginia.</b>                               |     |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>PENNINGTON &amp; SON</b>   |  | ADDRESS<br><b>Havre De. Grace, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 28 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |     |  |  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1814 CERTIFICATE OF DEATH

Reg. Dist. No.

01793

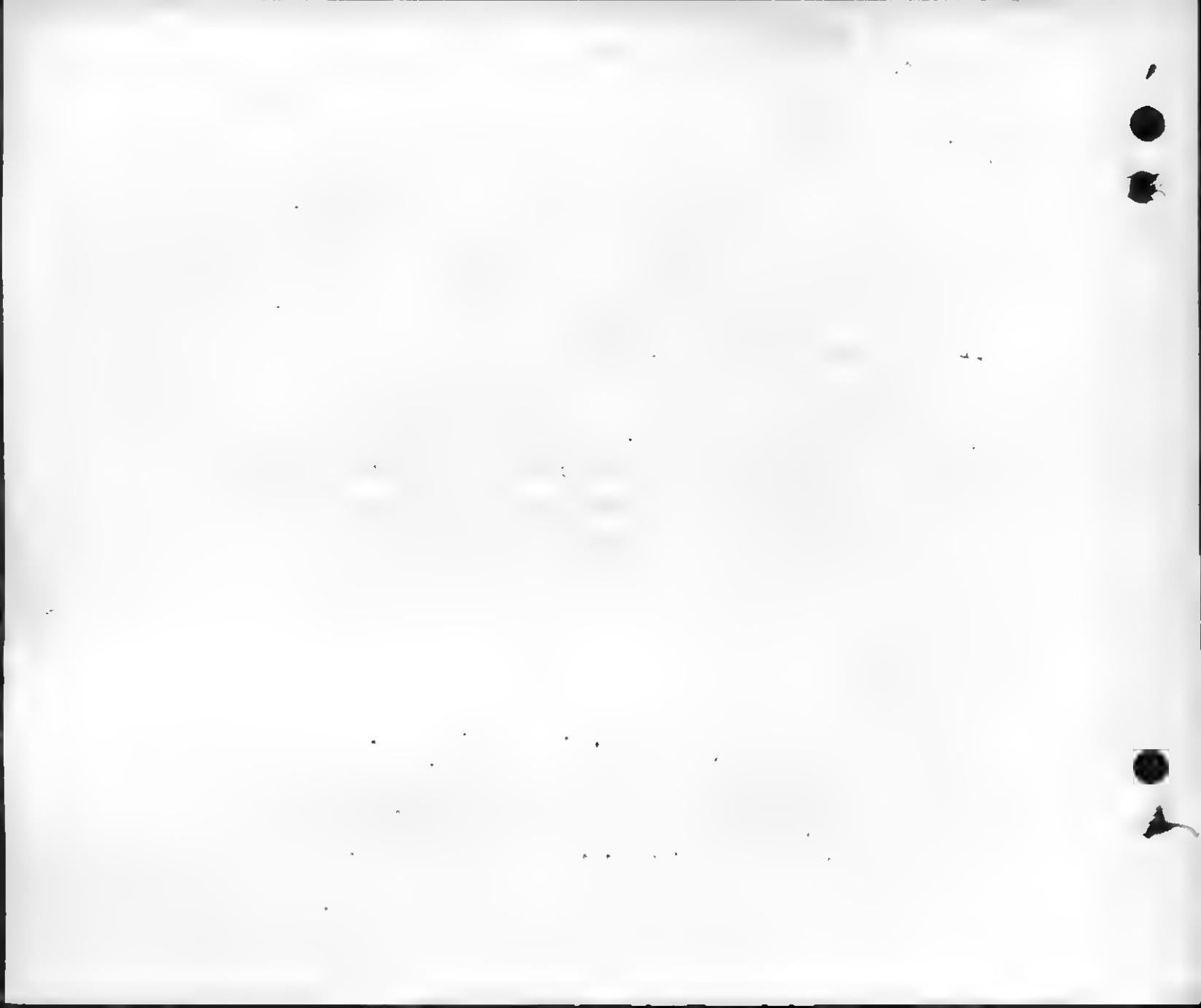
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death, may be retained by the physician or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |   | 2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission]<br>a. STATE<br><b>MARYLAND</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>   |   | c. LENGTH OF STAY IN 1b<br><b>10 Days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Union Hospital</b>   |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mae Louise Rowen</b>   |   | d. STREET ADDRESS<br><b>Rd # 4</b>  |  |
| First   | Middle  | Last  | 4. DATE OF DEATH<br>Month Day Year<br><b>2 15 19 61</b>  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W.</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 10, 1896</b>  |
| 9. AGE (In years lost birthday)<br><b>64 yrs</b>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b> | 11. KIND OF BUSINESS OR INDUSTRY<br><b>House Work</b>   | 12. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>   |
| 13. FATHER'S NAME<br><b>John Cato</b>   | 14. MOTHER'S MAIDEN NAME<br><b>Unkn.</b>  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  | 16. SOCIAL SECURITY NO.<br><b>-----</b>   | INFORMANT<br><b>Mrs Thomas McCarthy. Rd #4, Elkton, Md.</b>   | Address<br><b>-----</b>  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Afteriosclerotic coronary heart disease with severe angina pectoris</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)  |   |   |  |
| DUE TO  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)<br><b>Sept. 10 1960 Feb. 15 1961</b> |
| 21. I certify that I attended the deceased from <b>Feb 15 1961</b> , and that death occurred at <b>Elkton, Md.</b> from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE<br><i>S. Ralph Andrews, Jr.</i>  |   | ADDRESS (Street, city or town, state)<br><b>233 E. Main Street</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>S. Ralph Andrews, Jr., M.D.</b>   |   | DATE SIGNED<br><b>2/15/61</b>   |  |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>2/18/61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Elkton Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Elkton, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>N. Walter de Boos Jr.</i>  |   | ADDRESS<br><b>Elkton, Md.</b>   |  |
|   |   | 24a. REC'D BY REGISTRAR<br><b>DATE FEB 23 '61</b>   |  |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><i>Charles L. Knott</i>   |  |



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be examined within 24 hours after death by the attending physician or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

181.

**CERTIFICATE OF DEATH**

01794

|   |  |  |   |  |  |   |                             |                      |
|---|--|--|---|--|--|---|-----------------------------|----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>D. C.</b>  |   |  |  |   |                             |                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Perry Point, Md.</b>   |  | c. LENGTH OF STAY IN 1b<br><b>2 mo. 12 days</b>  |   |  |  |   |                             |                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Veterans Administration Hospital</b>   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |   |  |  |   |                             |                      |
| 3. NAME OF DECEASED (Type or print)<br><b>THOMAS</b>  |  | First<br><b>J.</b>   | Middle<br><b>SAVOY</b>  |  |  |   |                             |                      |
| 4. DATE OF DEATH<br><b>February 27 1961</b>   |  | Month<br><b>February</b>   | Day<br><b>27</b>  |  |  |   |                             |                      |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |   |                             |                      |
| 8. DATE OF BIRTH<br><b>9-15-92</b>  |  | 9. AGE (In years last birthday)<br><b>68 yrs</b>   | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   |  |  |   |                             |                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Police</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Special</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  |  |   |                             |                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>William Savoy (deceased)</b>   |   |  |  |   |                             |                      |
| 14. MOTHER'S MAIDEN NAME<br><b>Lottie Harding (deceased)</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |   |  |  |   |                             |                      |
| 16. SOCIAL SECURITY NO.<br><b>WW-1</b>  |  | 17. INFORMANT<br><b>Hospital Records, VAH, Perry Point, Md.</b>  | Address   |  |  |   |                             |                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>Peritonitis diffuse</b>                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>48-72 hrs.</b>  |   |  |  |   |                             |                      |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Adenocarcinoma, sigmoid, recurrent with widespread metastasis</b><br>(c) |  | unknown  |   |  |  |   |                             |                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |   |  |  |   |                             |                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m. <b>VA 19</b> |   | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>                             | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)<br><b>Arlington</b> | (County)<br><b>Virginia</b> | (State)<br><b>VA</b> |
| 21. I certify that <b>A. L. Mooney, Jr.</b> attended the deceased from <b>December 15, 1960, to February 27, 1961.</b> and that death occurred at <b>2:50 pm</b> on the date stated above.  |  |  |   | 21. I certify that <b>A. L. Mooney, Jr.</b> attended the deceased from <b>December 15, 1960, to February 27, 1961.</b> and that death occurred at <b>2:50 pm</b> on the date stated above. |  |   |                             |                      |
| 22a. SIGNATURE<br><b>A. L. Mooney, Jr.</b>  |  | M.D.<br><b>A. L. Mooney, Jr.</b>   | ATTENDING PHYS.<br><input type="checkbox"/>   | MED. DIRECTOR<br><input type="checkbox"/>  | STAFF PHYS.<br><input type="checkbox"/>                                | 22b. DATE SIGNED<br><b>2-28-61</b>      |                             |                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>  |  |  |   | 22d. ADDRESS   |  |   |                             |                      |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>REMOVAL</b>   |  | 23b. DATE THEREOF<br><b>3/3/1961</b>   | 23c. NAME OF CEMETERY OR CREMATORIAL<br><b>Arlington National</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Arlington, Virginia</b>    |   |                             |                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Pennington &amp; Son, Havre de Grace, Md.</b>  |  | ADDRESS  | 25a. REC'D BY REGISTRAR<br><b>MAR 7 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Krause</b>                 |   |                             |                      |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

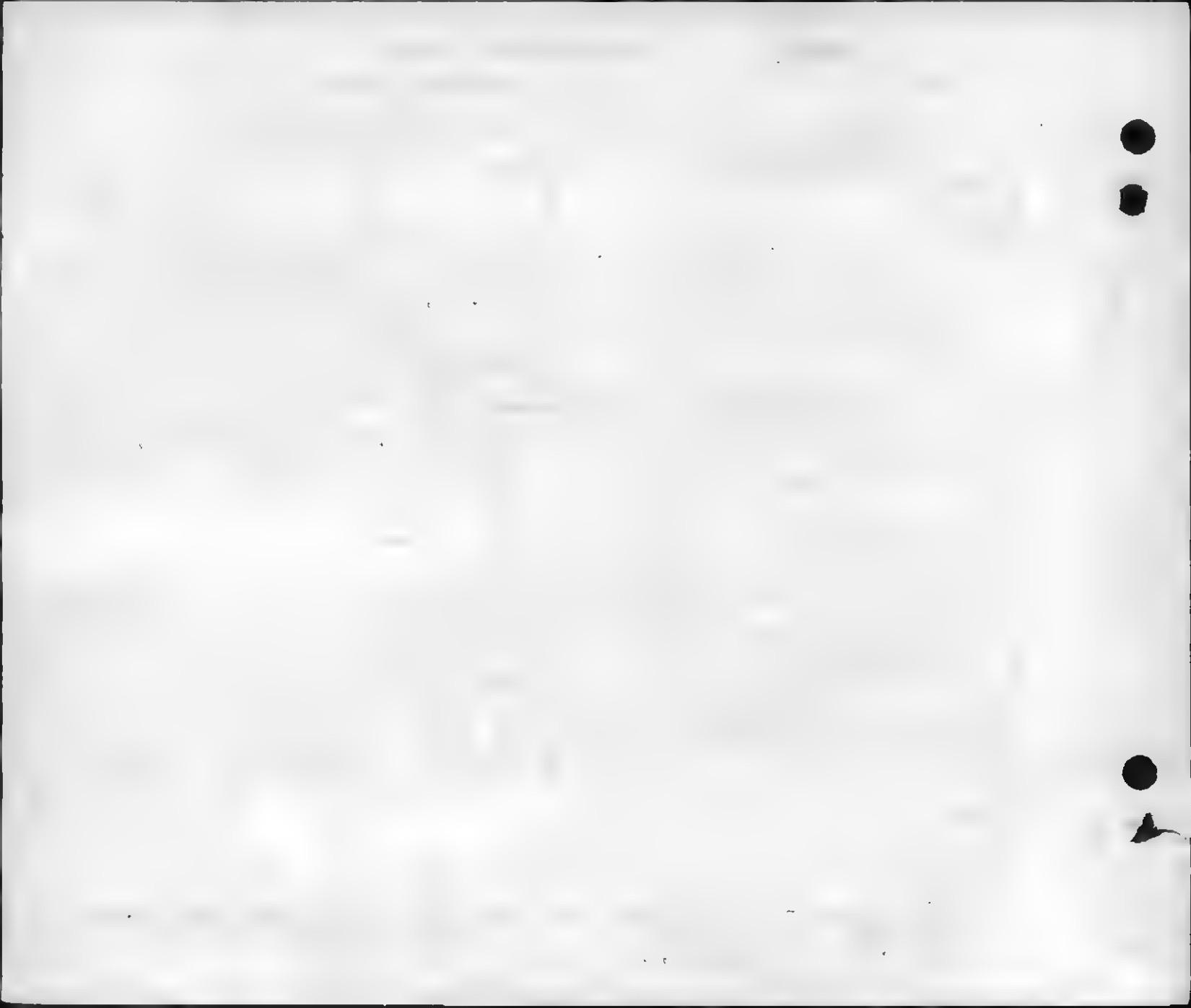
1816

## CERTIFICATE OF DEATH

Reg. Dist. No. 01795

|  |                                      |  |  |   |
|--|--------------------------------------|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b>             |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural North East</b>  |                                      | c. LENGTH OF STAY IN 1b<br><b>39 yrs</b>   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>—  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural North East</b>                      |  |   |
| d. STREET ADDRESS  |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  |   |
| 3. NAME OF DECEASED<br>(Type or print)   | First<br><b>Charles</b>              | Middle<br><b>R.</b>  | Last<br><b>Shifflett</b>   |   |
| 4. DATE OF DEATH   | Month<br><b>2</b>                    | Day<br><b>15</b>   | Year<br><b>19 61</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>white</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 10, 1880</b>  |   |
| 9. AGE (In years<br>last birthday)<br><b>80</b>  |                                      | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>  | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm Owner</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      | 13. FATHER'S NAME<br><b>no information</b>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>no information</b>  |                                      | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>If yes, give war or dates of service)<br><b>no</b>          |  |   |
| 16. SOCIAL SECURITY NO.<br><b>none</b>   |                                      | 17. INFORMANT<br><b>William F. Shifflett</b>   | Address<br><b>North East, Maryland</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Cerebral thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.<br><b>Hypertensive cardiovascular Rev. 1 Disease</b><br>DUE TO<br>(b) <b>3 years</b><br>DUE TO<br>(c) |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs.</b>   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)                                     |  |   |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.  | Month<br><b>June</b>                 | 20d. INJURY OCCURRED<br>White<br>Not white<br>of work <input type="checkbox"/> of work <input type="checkbox"/>                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |   |
| 21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>15 Feb.</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>15 Feb.</b> , 19 <b>61</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.  |                                      | ADDRESS (Street, city or town, state)<br><b>No. 16 E. 1st St.</b>  |  |   |
| ACTUAL SIGNATURE<br><b>Klaus H. Huebner</b>  | M.D.<br><b>Klaus H. Huebner M.D.</b> | DATE SIGNED<br><b>2/15/61</b>  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                      | 22b. DATE THEREOF<br><b>2-19-1961</b>  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Methodist</b>   | 22d. LOCATION (City, town, or county)<br>(State)<br><b>North East, Cecil Co., Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph R. Grant</b>   |                                      | ADDRESS<br><b>North East, Md.</b>  | 24a. REC'D BY REGISTRAR<br><b>FEB 23 '61</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Klaus</b>                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by hospital or attending physician.  
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Please forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1817

01793

1. PLACE OF DEATH  
a. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rising Sun

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

lyres

1817

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

e. STATE

Md.

b. COUNTY

Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rising Sun, Rural

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

Bob

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year  
19 61

5. SEX

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

5-8-1886

9. AGE (in years  
last birthday)

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

74 yrs

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Farmer Retired

10b. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

Tenn.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jasper Thomas

14. MOTHER'S MAIDEN NAME

Polly Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give rank or date of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

413-26-5039 Mrs. Bob Thomas, Rising Sun, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e.g.,

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m. p.m. 19

20d. INJURY OCCURRED  
Wh le  
at work  Not Wh le  
at work

20a. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)  
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

ACTUAL

R. C. Dodson

Rising Sun, Md.

2-19-61

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

Burial 2-23-1961

23. FUNERAL DIRECTOR

Union cem.

Mabel

N.C.

Jernard McMillan

Rising Sun, Md.

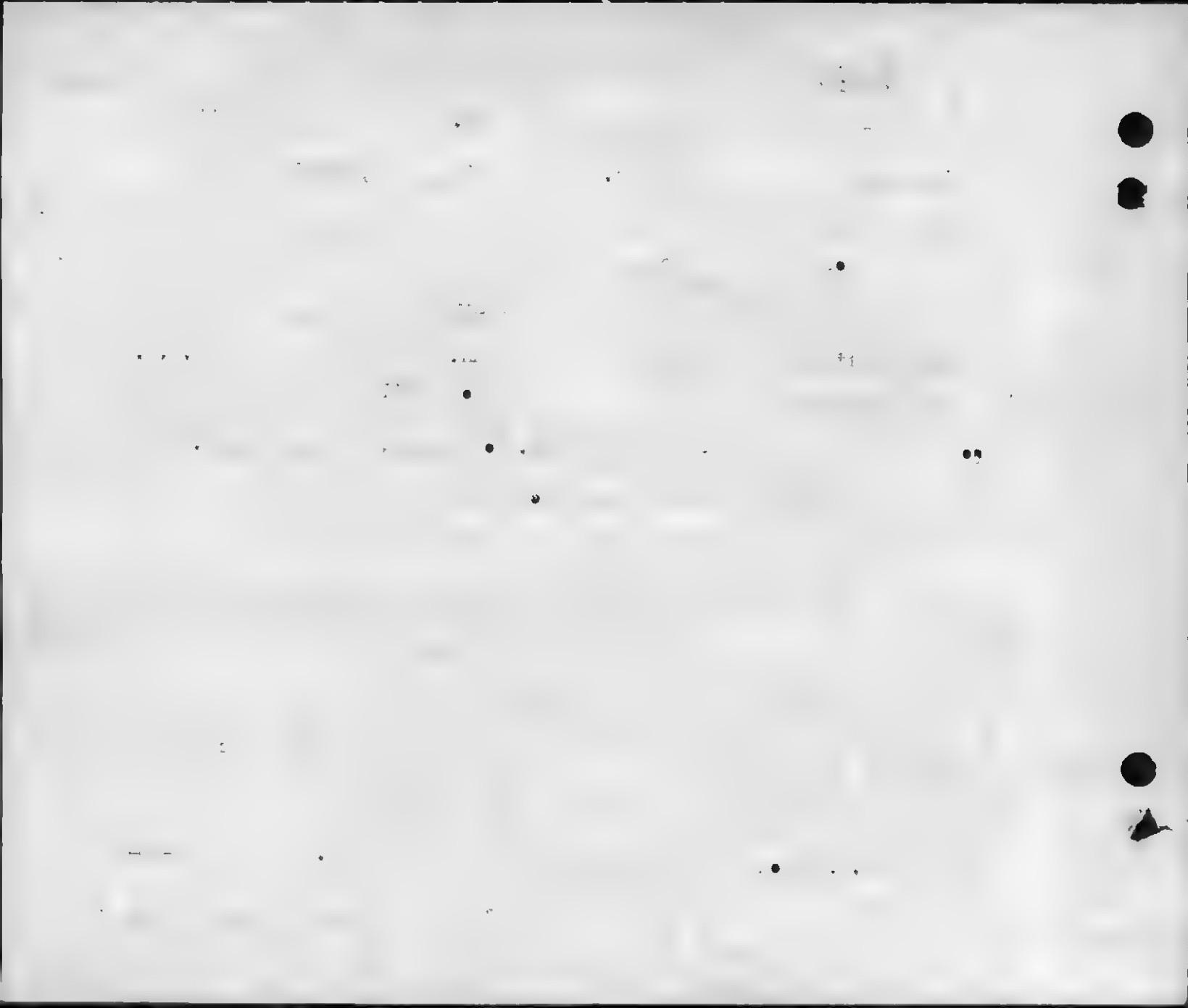
ADDRESS

REC'D BY REGISTRAR

DATE FEB 21 '61

REGISTRAR'S SIGNATURE

Charles S. Tamm



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1818

## CERTIFICATE OF DEATH

**TO HOSPITAL OR FUNERAL DIRECTOR:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived, if institutions, residence before admission)   |  |
| Cecil   |  | b. STATE Maryland  |  |
| b. CITY OR TOWN (if outside corporate limits, give RURAL and give nearest town)   |  | b. COUNTY Cecil  |  |
| Port Deposit  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |
| Lifetime  |  | X Port Deposit   |  |
| d. LENGTH OF STAY IN 1b   |  | d. STREET ADDRESS  |  |
| Lifetime  |  | 17 Granite St.   |  |
| e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  | Last   |  |
| 17 Granite Street   |  | 4. DATE OF DEATH Feb 4 1961  |  |
| f. NAME OF DECEASED<br>(Type or print)  |  | Month Day Year   |  |
| Mary Josephine Townsend   |  | 5. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| g. SEX Female   |  | 6. COLOR OR RACE Negro   |  |
| h. MARRIED <input checked="" type="checkbox"/>  |  | 7. NEVER MARRIED <input type="checkbox"/>  |  |
| WIDOWED <input type="checkbox"/>  |  | B. DATE OF BIRTH March 9, 1901   |  |
| i. KIND OF BUSINESS OR INDUSTRY Housewife   |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR<br>Months Days Hours M.n.  |  |
| j. BIRTHPLACE (County & State, or foreign country) Port Deposit, Md   |  | 10. CITIZEN OF WHAT COUNTRY? U. S. A.  |  |
| k. FATHER'S NAME George E. Stewart  |  | 11. MOTHER'S MAIDEN NAME Alice Lee Thomas  |  |
| l. WAS DECEASED EVER IN J.S. ARMED FORCES? No   |  | 12. ADDRESS Box 102  |  |
| m. SOCIAL SECURITY NO   |  | 13. INTERVAL BETWEEN<br>ONSET AND DEATH  |  |
| n. INFORMANT none   |  | 14. DECEASED -   |  |
| o. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>455 DUE TO<br>Conditions, if any, which<br>give rise to immediate cause<br>(b).<br>(c), stating the underlying<br>cause last. |  | 15. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| p. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Parties - Heart trouble   |  | 16. TIME OF INJURY Month, Day, Year<br>Hour a.m. 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 20d. INJURY OCCURRED While at work<br>p.m. 19 Not While at work   |  |
| q. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)   |  |
| r. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)  |  | 21. I certify that (I) (this hospital) attended the deceased from Feb 3, 1961, to Feb 3, 1961, that (I) (we) last saw the deceased alive on Feb 3, 1961, and that death occurred at 2 P.M. from the causes and on the date stated above. |  |
| s. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.<br>22d. ADDRESS  |  | 22b. DATE SIGNED<br>Feb 5, 1961  |  |
| t. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 23c. NAME OF CEMETERY OR CREMATORIAL Cemetery  |  |
| 23b. DATE THEREOF Feb 7, 1961   |  | 23d. LOCATION (City, town or county) Cokebury, Cecil Md.   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus  |  | 25e. REC'D BY REGISTRAR FEB 8 '61  |  |
| ADDRESS 532 N. Main St., Laurel, Md.  |  | 25b. REGISTRAR'S SIGNATURE   |  |

1 5

21

17 28

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

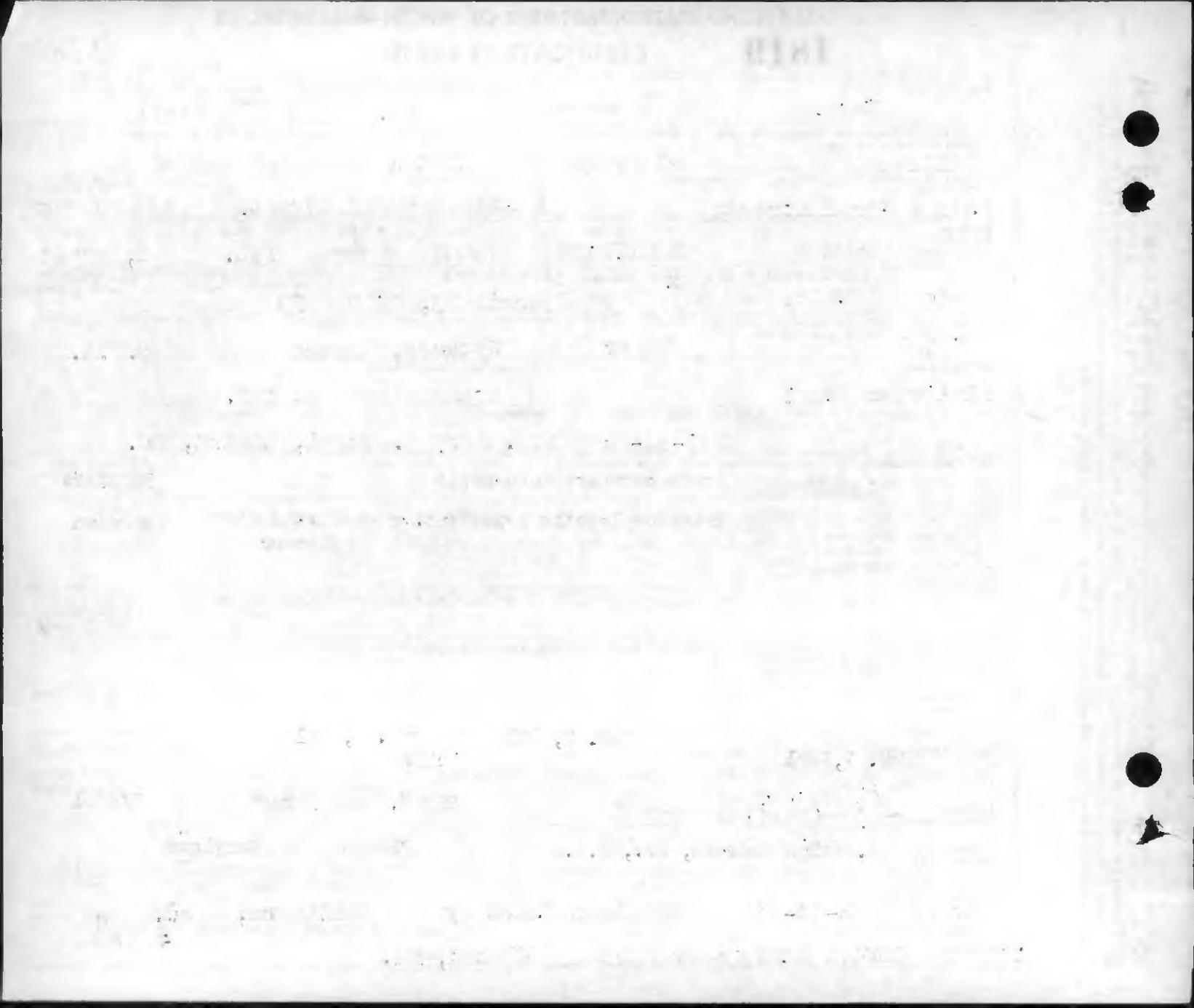
## 1819

### CERTIFICATE OF DEATH

Reg. Dist. No.

01798

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Md.</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>   |   | b. COUNTY<br><b>Cecil</b>   |  |
| c. LENGTH OF STAY IN 1b<br><b>41 years</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkton</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Main &amp; North Streets</b>  |   | d. STREET ADDRESS<br><b>Main &amp; North Streets</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br><b>GEORGE</b>                                | Middle<br><b>DIMITRIOS</b>  | Last<br><b>VAGGI</b>   |
| 4. DATE OF DEATH  | Month<br><b>Feb.</b>                                  | Day<br><b>8,</b>  | Year<br><b>1961</b>  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>                      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 23, 1890</b>  |
| 9. AGE (In years<br>last birthday)<br><b>70</b>   | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>             | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  | 12. IF UNDER 24 HRS.<br>Hours<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Hotel</b>  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Owner</b>     | 11. BIRTHPLACE (State or foreign country)<br><b>Kythera, Greece</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |
| 13. FATHER'S NAME<br><b>Dimitrios Vaggi</b>   | 14. MOTHER'S MAIDEN NAME<br><b>Evangeline No Inf.</b> |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  | 16. SOCIAL SECURITY NO.<br><b>215-32-9209</b>         | INFORMANT<br><b>Mrs. Mary G. Vaggi, Elkton, Md.</b>   | Address  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Acute coronary thrombosis</b>  |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>30 hours</b>  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br><b>Arteriosclerotic hypertensive cardiovascular disease</b>  |   | unknown   |  |
| DUE TO<br>(b)<br>DUE TO<br>(c)  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Doy, Year<br>Hour a. m.                          19<br>p. m.   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while<br>of work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, Farm,<br>factory, street, office bldg., etc.)<br><b>Feb. 7, 1961</b> |
|   |   |   | 20f. (City or town)<br><b>Feb. 8, 1961</b>   |
|   |   |   | (County) <b>Baltimore</b> (State) <b>Md.</b>   |
| 21. I certify that I attended the deceased from <b>Feb. 7, 1961</b> , to <b>Feb. 8, 1961</b> , that I last saw the deceased alive on <b>Feb. 7, 1961</b> , and that death occurred at <b>233 E. Main Street</b> , M., from the causes and on the date stated above. |   |   |  |
| ACTUAL<br>SIGNATURE<br><i>S. Ralph Andrews, Jr.</i>   |   | ADDRESS (Street, city or town, state)<br><b>Elkton Maryland</b>   |  |
| PHYSICIAN'S<br>NAME (Type)<br><b>S. Ralph Andrews, Jr., M.D.</b>  |   | DATE SIGNED<br><b>2/8/61</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>2-11-61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Woodlawn Cemetery</b>  |   | 22d. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>PIPPIN FUNERAL HOME</b>  |   | 24a. REC'D BY REGISTRAR<br><b>FEB 14 1961</b>   |  |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>   |  |



FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01799

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Cecil</b>  | MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE<br><b>Md.</b>   | b. COUNTY<br><b>Cecil</b>   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rainbridge</b>   | c. LENGTH OF STAY IN lb<br><b>1 mo. 29 days</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rainbridge Port Deposit</b>  | d. STREET ADDRESS<br><b>119C Preston Drive Manor Heights</b>                    |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U.S. Naval Training Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Jo Layne</b>   | First<br><b>Marie</b>  | Middle<br><b>Young</b>  | 4. DATE OF DEATH<br>Last<br><b>2 7 19 61</b>                                    |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-8-60</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Infant</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |
| 13. FATHER'S NAME<br><b>Robert David Young</b>  | 14. MOTHER'S MAIDEN NAME<br><b>Donna Marie Cameron</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>-----</b>  | 17. INFORMANT<br><b>Robert Davis Young, 119C Preston Drive Manor</b>  | Address <b>Heights, Port Depo</b>   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Oedema</b>  | INTERVAL BETWEEN ONSET AND DEATH   |   |   |
| 522X<br>Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.<br>} DUE TO<br>(b) <b>( Pending chemical examination, iff different another</b>  |  |   |   |
| } DUE TO<br>(c) <b>certificate will be issued)</b>  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |
| 20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)           |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>(County)</b>   | (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |
| ACTUAL SIGNATURE<br><b>R.C. Dodson</b>  | M.D.   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   | DATE SIGNED<br><b>2-7-61</b>  |
| EXAMINER'S NAME (Type)<br><b>R.C. Dodson</b>  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>2-9-1961</b>   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Cherry Creek Cem.</b>  | 22d. LOCATION (City, town, or country) (State)<br><b>Cherry Creek, New York</b> |
| 23. FUNERAL DIRECTOR<br><b>Vera Patterson &amp; Son,</b>  | ADDRESS<br><b>Perryville, Md.</b>  | 24a. REC'D BY REGISTRAR<br><b>FEB 9 '61</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                            |

